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ABSTRACT

This report presents the analytical results of a survey of U.S. baccalaureate nursing schools conducted during 1999 by the American Colleges of Nursing with a description of the extent of women's health content in the curriculum and selected recommendations designed to strengthen this content. Additional resources are included that describe the essentials of baccalaureate nursing education, fundamental features of women's health care, and the significant contribution of nurses in providing comprehensive women's health care. The survey was sent to deans or directors at 521 schools in the United States that had entry level baccalaureate nursing programs. Responses were received from 334 schools (64%). Results of the survey show that a large majority of entry-level baccalaureate nursing education programs do include a high percentage of women's health topics in the curriculum. One topic (the impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care use) was included in the curriculum of every school reporting. Domestic violence and rape were included in the required course content of 95% and 92% of the nursing education programs, and childhood abuse was included in 94% of the programs reporting. Areas for improvement are identified, and some specific recommendations are made. Nine appendixes contain supplemental information related to the survey methods and findings. Survey instrument is included. (Contains 38 tables and 19 references.) (SLD)

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ED 464 547

Women's Health

in the Baccalaureate Nursing School Curriculum

Report of a Survey and Recommendations

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NURSING RESEARCH

OFFICE OF RESEARCH ON WOMEN'S HEALTH

Department of Health and Human Services
Office on Women's Health

HED348602

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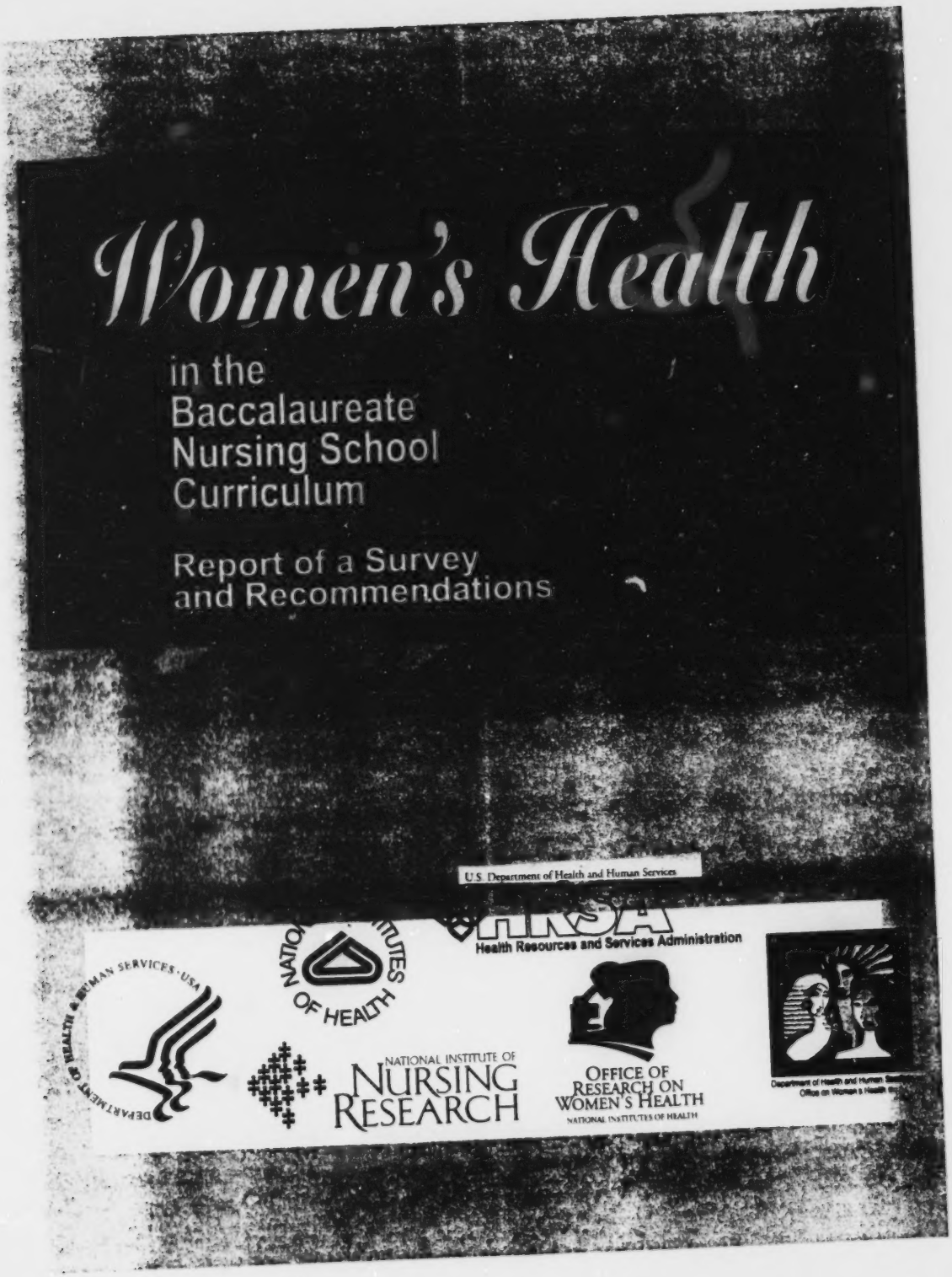
This report is based on data collected by the American Association of Colleges of Nursing. The analysis and report were accomplished in collaboration with and support from the Health Resources and Services Administration's (HRSA) Office of Women's Health and the Bureau of Health Professions, Division of Nursing, the National Institutes of Health's (NIH) Office of Research on Women's Health (ORWH) and the National Institute of Nursing Research (NINR), and the Department of Health and Human Services' Office on Women's Health (OWH) through purchase order number BHPR-98-0584(P).



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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

Dear Colleague:

The Health Resources and Services Administration's (HRSA) Division of Nursing and HRSA's Office on Women's Health, the National Institutes of Health's (NIH) Office of Research on Women's Health and National Institute of Nursing Research (NINR) and the Department of Health and Human Services' Office on Women's Health (OWH) are pleased to provide you with a copy of *Women's Health in the Baccalaureate Nursing Curriculum: Report of a Survey and Recommendations*. This is a comprehensive survey that examines how women's health and sex/gender-related issues are taught in the academic and clinical course of study for baccalaureate nursing students.

This report is the result of a collaborative project undertaken by these agencies in response to a Congressional directive to assess women's health content in health professions education. It complements previous studies sponsored by these agencies on women's health content in medical and dental education. The design of the survey, findings, and recommendations also build on previous analyses and recommendations for change made by nursing professional associations. All health professionals, regardless of discipline and specialization, need to have a full understanding of women's health issues which is grounded in an awareness of the context of women's lives, combined with the knowledge, skills, and competence to provide optimum care to women of all ages. In order to achieve this goal, the study of women's health across the life span needs to be fully integrated into the curricula of nursing and other health profession schools.

The analytical results of a survey of U. S. baccalaureate nursing schools conducted during 1999 by the American Association of Colleges of Nursing (AACN) are presented with a description of the extent of women's health content in the curriculum and selected recommendations designed to guide educators in strengthening this content. Additional resources are included that describe essentials of baccalaureate nursing education, fundamental features of excellent women's health care, and the significant contribution of nurses in providing comprehensive women's health care.

We wish to acknowledge the vital effort of the AACN, its staff and expert advisory and technical working group in the preparation of this resource document. This report significantly contributes to the understanding of the educational and clinical aspects of women's health and provides an overview of how baccalaureate level nurses are being prepared to positively influence women's health throughout the life span.

We hope that this publication will be of value to you in efforts to strengthen both the women's health academic and applied learning experiences for all nurses.

Sincerely yours,

Wanda K. Jones, Dr.P.H.
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PREFACE

In 1992, in Congressional appropriations report for Fiscal Year 1993, the Senate and House requested that the Office of Research on Women's Health (ORWH) of the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and the Office on Women's Health (OWH) of the Department of Health and Human Services (DHHS) (formerly the Public Health Service Office on Women's Health) work together to describe the extent to which women's health content is included in the medical curriculum. In 1993, in the FY 1994 appropriations report, Congress broadened its concern to curricula of all health professionals. The Director of the ORWH, the HRSA Senior Advisor, Women's Health and program staff of the Bureau of Health Professions responded to these requests for assessments of curricula of health professionals education, beginning first with medicine, to set a format and model instrument that could be used for other health professions. The result was the first of these reports, *Women's Health in the Medical Curriculum, Report of a Survey and Recommendations* published in 1996, and then followed by the report *Women's Health in the Dental School Curriculum, Report of a Survey and Recommendations,* in 1999. Having fully intended to address women's health in the nursing curriculum, this report represents the culmination of that collaborative effort. With the work of the American Association of Colleges of Nursing (AACN), supported by the Department of Health and Human Services' OWH, HRSA, and NIH's ORWH and the National Institute of Nursing Research (NINR), this historic document, representing the first comprehensive review of women's health in nursing curricula, has been prepared. We must acknowledge the work of the AACN in undertaking the survey to obtain the data and for the writing and preparation of this report, particularly Joan Stanley, Ph.D., R.N., Director of Education Policy, Linda Berlin, Dr.P.H., R.N. C., Director of Research and Data Services, Frances Weed, M.S.N., R.N., Director of Special Projects, and Emily Schmid, Education Policy and Program Assistant.

During the last decade scientists, clinicians, and the public have become increasingly aware of the inequities in women's health, such as the instances of failure to include adequate numbers of women as participants in clinical trials, and the consequences of inadequate attention to sex/gender differences in clinical trials. Attention was also focused on the lack of funding for specific women's health concerns, the barriers to accessing health care services, the lack of focus on women's health concerns in consumer and professional education, and the dearth of women in senior health and scientific positions in our Nation's public and private academic and health care institutions and organizations.

Federal efforts to address specific women's health issues, especially research on women's health, have intensified since 1990, including the education of health professionals about the expanded concepts of women's health across the life span, beyond the reproductive system and with sex/gender comparisons. (See Timeline page iv)

TIMELINE FOR WOMEN'S HEALTH RESEARCH

1983
Assistant Secretary for Health established the Public Health Service Task Force on Women's Health issues.

1985
PHS published *Women's Health Report of the Public Health Service Task Force on Women's Health.*

1986
National Institutes of Health (NIH) established Advisory Committee on Women's Health Issues, which recommended increasing women's participation in biomedical research.

1987
NIH policy of 1986 was reissued with emphasis on inclusion of minorities.

NIH developed and published a policy statement in the *NIH Guide for Grants and Contracts* advising applicants to include women in clinical studies.

1989
Congressional Caucus for Women's Issues introduced the Women's Health Equity Act Omnibus bill.

Caucus and House of Representatives Subcommittee on Health and Environment called for GAO investigation of NIH implementation of 1986 policy.

1990
The GAO report indicated that implementation of the NIH guidelines for inclusion of women was lacking.

Office of Research on Women's Health (ORWH) established; Dr. Ruth Kirschstein appointed as acting director.

NIH mandated inclusion of women for all research grants.

1991

Dr. Bernadine Healy appointed as the first woman NIH director. She proposed Women's Health Initiative.

Dr. Vivian Pinn appointed as first director of Office of Research on Women's Health (ORWH).

ORWH convened Hunt Valley Conference, "Opportunities for Research on Women's Health."

1992

ORWH held public hearing and conference on recruitment and retention of women in biomedical careers.

Fred Hutchinson Cancer Research Center contracted as the Clinical Coordinating Center for the WHI.

1993

Women's Health Initiative (WHI) subject recruitment began for prevention trials.

ORWH held public hearing and scientific workshop on recruitment and retention of women in clinical studies.

1993 NIH Revitalization Act (P.L. 103-43) passed; established ORWH in law and mandated inclusion policy for NIH-supported studies.

FDA published new guidelines for study of gender differences in clinical evaluation of drugs.

Congress requested that ORWH and other organizations survey the status of women's health education and training in medical school curricula.

First Vanguard Clinical Centers contracted for WHI.

1994

ORWH published two reports from conferences: *Women in Biomedical Careers; Dynamics of Change, Strategies for the 21st Century* and *Recruitment and Retention of Women in Clinical Studies*.

IOM released a report, *Women and Health Research*, funded by ORWH.

Remaining 24 Clinical Centers were contracted for WHI.

1995

WHI completed selection of all 40 clinical centers for the intervention clinical trials.

ORWH, with HRSA and PHS/OWH, supported report to evaluate current curricula on women's health in U.S. and Canadian medical schools.

1996

ORWH, HRSA, and PHS/OWH published *Women's Health in the Medical School Curriculum*.

ORWH began a four-part series of public hearings and scientific workshops to updated and revise the women's health research agenda for the 21st century.

IOM released report, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*.

1997

Beyond Hunt Valley: Research on Women's Health for the 21st Century continued.

ORWH released two publications, *News & Features: Research on Women's Health* and *Women of Color Health Data Book*.

1998

ORWH released *Women of Color Health Data Book* in Spanish.

IOM released *Gender Differences in Susceptibility to Environmental Factors*.

Recruitment for the WHI successfully closed.

ORWH, NINR, HRSA and OWH supported the beginning evaluation of women's health curriculum in the baccalaureate nursing program.

1999

ORWH and HRSA released a report on *Women's Health in the Dental School Curriculum*.

IOM released report, *Lesbian Health: Current Assessment and Directions for the Future*.

ORWH released a six-volume report on a revised and updated *Agenda for Research on Women's Health for the 21st Century*.

ORWH and FDA sponsored workshop "Biologic and Molecular Mechanisms for Sex Difference in Pharmacokinetics, Pharmacodynamics and Pharmacogenetics."

2000

ORWH released report, *Achieving Excellence in Science*.

GAO followup report, *NIH Has Increased Its Efforts to Include Women in Research*.

ORWH celebrates its 10th anniversary.

Source: National Institutes of Health, Office of Research on Women's Health, 2000.

Through collaboration between HRSA, NIH, the OWH, the AACN and other private organizations, significant progress is now underway in increasing awareness of the urgent need to incorporate an innovative, multidisciplinary and interdisciplinary, life-span approach to women's health into the education of future health professionals, including nurses. There is growing appreciation that it is not enough to focus only on the biological basis of disease in nursing education when behavioral and environmental factors also have a significant effect on the health of women and men; these factors contribute over 50 percent of the causation of the 10 leading causes of death in America. To improve the health care of women throughout the life span it is imperative that students of nursing learn about women's health issues and sex/gender differences throughout their program of study, addressing these issues in a cross cutting way throughout both the didactic portion of the curriculum and the clinical application of knowledge. This knowledge is essential to translating research into practice through comprehensive preventive and curative services, and reaching other goals, for the improved health status of girls and women across the life span.

This report also provides baseline information that can increase the awareness of policy makers and educators about the full range of content needed for an appreciation of the expanded concepts of women's health. Development of specific clinical competencies in women's health care expected in the baccalaureate-nursing graduate is viewed as an important next step. The collaborative partnership between Federal government agencies and other private organizations is committed to stimulating progressive comprehensive attention to achieving the recommendations that flow from this study and report. We are grateful for the dedicated assistance to this effort from the AACN, without whose effort this report would not have been possible.

We believe this document contains important information about what is or could be included in the curriculum and may provide a springboard for addressing competencies related to women's health issues and sex/gender factors in health and disease. We hope that this information can and will serve as a resource for institutions to consider in modifying their own curriculum as needed to improve the health care of women and men across their life span.

Wanda K. Jones, Dr.P.H.
Deputy Assistant Secretary for Health
(Women's Health)
Department of Health and Human Services

Betty B. Hambleton
Former Senior Advisor
Women's Health
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EXECUTIVE SUMMARY

Congressional directives in 1992 initiated exploration into educational curricula of health care professionals. As the largest health profession, nursing has a significant impact on the delivery of health care in this country. Therefore, in order to adequately ascertain the extent to which women's health issues are addressed in health professions education, the nursing education curriculum needed to be examined. In 1998, the American Association of Colleges of Nursing (AACN) undertook a project to describe the curriculum content related to women's health included in entry-level baccalaureate nursing programs. The project was initiated in collaboration with and partial support from the Health Resources and Services Administration's (HRSA) Division of Nursing, HRSA's Office of Women's Health, the National Institutes of Health's (NIH) Office of Research on Women's Health (ORWH), the National Institute of Nursing Research, and the Department of Health and Human Services' Office on Women's Health (OWH). The project was designed to build on the work previously done on women's health curricular content in medical and dental schools and to offer recommendations for strengthening women's health content in entry-level baccalaureate nursing education.

Members of the nursing profession have a long tradition of providing health services to women. From the inception of modern nursing to the present, nurses have been concerned with promoting the health of women and their families. New realities of health care require professional nurses to master complex information, coordinate a variety of care experiences, use technology for health care delivery and evaluation, and assist patients with managing an increasingly complex system of care (AACN, 1998).

In December 1998, AACN convened a Women's Health Advisory Group to provide advice and guidance for this project. Representatives from eight national nursing organizations, five federal offices with an interest in women's health, the Association of American Medical Schools, and the American Association of Dental Schools comprised the advisory group.

In August-September 1999, AACN conducted a survey of schools of nursing that offer entry-level baccalaureate nursing education programs in order to determine what is currently taught regarding women's health. Additionally, the survey addressed:(a) whether the content was included in the required or elective curriculum; (b) how the material was presented (as a lecture, in a small group discussion or seminar, in clinical practicum, or as a self-study); and (c) by which disciplines or specialties the material primarily was taught.

For the purpose of this project the following working definition was used:

> Women's health refers to health and illness issues that are unique to or more prevalent or serious in women, have causes or manifestations specific to women,

and occur across the life span and within the context of women's lives. Such context includes but is not limited to:

- Environment
- Social status
- Economic class
- Political belief and/or affiliation
- Ethnicity
- Cultural background
- Developmental stage
- Biologic and/or genetic makeup
- Spirituality

The intent of all of the health professional curriculum projects was to examine entry-level professional education. In nursing this occurs at the baccalaureate level rather than at the graduate level, as is the case with medicine and dentistry. Nurses prepared at the graduate level have a significant impact on women's health care in the U.S. However, the examination of women's health content in graduate nursing education programs would entail a separate curriculum survey and, therefore, was beyond the scope of this project.

The medical and dental school curriculum surveys provided the basic format for the design of the nursing curriculum survey. In order to allow comparison of data among the nursing, medical, and dental school curriculum surveys, format of the survey and appropriate content areas were left relatively intact. Some specific questions and content areas were reworded, added, or deleted in order to make the survey and approach relevant to baccalaureate nursing education and holistic nursing practice.

The survey was sent to the deans/directors of the 521 schools in the United States that had one or more entry-level baccalaureate nursing education programs. Three hundred thirty-four surveys were completed and returned for an overall response rate of 64 percent. This response rate is similar to the rate obtained for the medical school survey (63%) but lower than the dental school survey (88%).

An introductory section of the survey explored general questions, including whether schools have a separate office/program responsible for ensuring the integration of women's health and gender-related issues into the curriculum and whether there are specific mechanisms to assist faculty in increasing their competence in women's health. The remainder of the survey covered 10 broad content areas and 117 specific topics related to women's health.

Results of the survey showed that a large majority of entry-level baccalaureate nursing education programs do include a high percentage of women's health topics in the curriculum. One topic (the impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care use) was included in the baccalaureate curriculum — either the required (98%) or elective (2%) course content — of every school reporting.

Domestic violence and rape were included in the required course content of 95 percent and 92 percent, respectively, of the baccalaureate nursing education programs. Childhood sexual, physical, and emotional abuse was included in 94 percent of the programs' required course content. These numbers are extremely important because nurses frequently are the first contact for many women and children with the health care system. Of the remaining 113 topics, 14 others were included in the curriculum of all but 1 percent or less of the baccalaureate nursing programs reporting information.

Despite the heavy emphasis on women's health issues in the baccalaureate nursing curriculum, there are areas for improvement. Only 81 percent of the responding programs included cultural competence in communicating with women. Of the 117 individual women's health topics, two (lesbian health issues and health issues for women with disabilities) were included in less than 50 percent of the schools' required course-work and were not offered at all in 42 percent and 37 percent, respectively, of the baccalaureate nursing curricula. The etiology, prevalence, course, treatment, and prevention of conditions specifically in women (e.g., cardiovascular disease, diabetes, osteoporosis, and urinary incontinence) was the broad content area least frequently included in the required course content of baccalaureate nursing programs. Many of these conditions may be included in the baccalaureate nursing curriculum but not with the specific focus on women and women's health. As health care research continues to identify differences between the biological and behavioral responses of men and women, a greater emphasis must be placed on the differences that exist in these and other common health conditions.

Nursing, as a profession dominated by women, traditionally has placed a greater emphasis on women's health than have other health professions. However, with the growing diversity and aging of the population and specifically the female population, nursing must further examine its current and potential role in addressing the health care needs of this large and growing segment of the population. A majority of nursing schools, as shown by this survey, recognize the importance of women's health in the preparation of future professional nurses. Nursing education and practice traditionally have emphasized a holistic approach to health that encompasses care across the entire life span and is sensitive to such variables as age, sex and gender, culture, race, religion, socioeconomic status, and lifestyle choice. This holistic approach spawns the heavy emphasis on women's health issues in the baccalaureate nursing curriculum. Continued vigilance, however, must be maintained to ensure that an even higher percentage of baccalaureate nursing programs graduate individuals who are prepared to address the specific health care needs of women across the life span.

Based on the information provided by this survey and recommendations put forth previously in the nursing literature, the following recommendations are made regarding advancing women's health in the nursing profession and for strengthening the entry-level baccalaureate nursing education curriculum.

In order to advance women's health in nursing education it is recommended that:

1. Faculty must be vigilant regarding the retention of women's health content currently included in the baccalaureate nursing curriculum.

2. Faculty in schools of nursing should examine the current baccalaureate curriculum to ensure that women's health care issues across the life span are addressed.

3. Women's health content should be approached in the context of environmental, social, economic, political, racial/ethnic, cultural, developmental, spiritual, and biologic factors.

4. Women's health curriculum content should reflect the degree and extent of diversity among women in the population.

5. The baccalaureate nursing curriculum should prepare graduates to work in interdisciplinary teams to provide comprehensive, quality women's health care.

6. Faculty in baccalaureate nursing programs should determine whether the clinical experiences offered are adequate to allow the integration of women's health knowledge and skills into the graduate's comprehension and daily practice.

7. The following specific content areas should be given greater emphasis in the baccalaureate nursing curriculum:
   - gender-specific communication styles and cultural competence in communicating with women;
   - health consequences of traumas experienced by women, including childhood sexual/physical/emotional abuse, domestic violence, rape, other criminal victimization, discrimination/oppression, and workplace harassment;
   - gender-specific health care decision making;
   - physical fitness and nutrition as approaches to health behaviors/health promotion in women;
   - sex and gender differences in the etiology, prevalence, course, treatment, and prevention of specific conditions, e.g., cardiovascular disease, respiratory disorders, or gastrointestinal disorders;
   - lesbian and gay health issues; and
   - health issues for women with disabilities.

8. Leaders in schools of nursing and national nursing organizations should place greater emphasis on faculty development in the area of women's health for faculty who teach in baccalaureate nursing programs and/or are involved in curriculum development at their institutions.

9. Officials of appropriate agencies and professional organizations should initiate a study that examines the quality and characteristics of clinical experiences and student outcomes related to women's health in baccalaureate nursing programs.

10. Appropriate agencies, professional organizations and educational institutions should collaborate to develop a framework for integrating women's health content

throughout the baccalaureate nursing curriculum, to include terminal competencies and resources for teaching women's health content.

11. Federal agencies or professional organizations should initiate a study to examine the nature and depth of women's health content in graduate nursing education programs, particularly those that do not have a specific focus on women's health.

More generally, it is recommended that:

12. Faculties at all schools of nursing, medicine, pharmacy, and dentistry should increase collaboration and share resources and expertise in order to advance women's health issues within health professions education.

13. At those institutions that have a National Center of Excellence in Women's Health, faculty in the school of nursing, school of medicine, and other health professions schools should strengthen communication and collaboration to improve the comprehensive nature of and access to appropriate women's health care services and education.

14. Faculty in nursing schools with expertise in women's health should offer an undergraduate course in women's health issues that would be acceptable and available to students with majors other than nursing.

15. The National Council of State Boards of Nursing should review and revise the national registered nurse licensure examination to reflect the importance of knowledge related to women's health care.

INTRODUCTION

In the 1990s there were major efforts to direct greater national attention to women's health research and women's health care. The Office of Research on Women's Health (ORWH) was established within the National Institutes of Health (NIH) in September 1990 to serve as the focal point for women's health research at NIH. The establishment of the Department of Health and Human Services' Office on Women's Health (DHHS/OWH) followed soon after in 1991. The Substance Abuse and Mental Health Services Administration (SAMHSA) also established a legislatively mandated women's health office, an Associate Administrator for Women's Services, in 1992. The Food and Drug Administration (FDA) Commissioner named a Special Assistant for Women's Health Issues in 1991 and in 1994 the FDA established an Office of Women's Health which is responsible for coordinating women's health issues and activities. Subsequently, other agencies within DHHS, including the Agency for Healthcare Research and Quality (previously known as the Agency for Health Care Policy and Research), the Centers for Disease Control and Prevention, the Health Resources and Services Administration (HRSA), and the Indian Health Service administratively created offices or senior level leadership positions focusing on women's health issues. In addition to the Federal focus during this decade, many consumer advocacy and professional women's health organizations were very active in advancing the scope and quality of the health care of women throughout the life span, as well as ensuring Federal attention to minority and other populations of women with disparate health status.

Concurrently, there was an increase in the breadth and depth of knowledge related to women's health and recognition of the need for its incorporation into the education of health care professionals. Congressional directives in 1992 initiated exploration into curricula of health care providers. (Congressional language regarding women's health curriculum is included as Appendix A.) Collaborative efforts of the NIH Office of Research on Women's Health (ORWH), the Health Resources and Services Administration (HRSA), the DHHS/OWH, and the Association of American Medical Colleges (AAMC) resulted in a survey of medical schools' curricula. *Women's Health in the Medical School Curriculum: Report of a Survey and Recommendations* (1996) summarized the extent women's health issues were and should be integrated into medical school curricula.

To further the investigation of models of education and teaching a life-span approach to women's health, a survey of U.S. and Canadian dental schools was initiated in 1997. The American Association of Dental Schools (AADS), in collaboration with NIH/ORWH and HRSA, assumed responsibility for the design and analysis of the curriculum survey to describe current dental school efforts to address women's health in curriculum content. The medical school curriculum survey provided a framework for the AADS survey. *Women's Health in the Dental School Curriculum: Report of a Survey and Recommendations* (1998) includes recommendations to "generate interest and action with regards to gender issues in dental school curricula" (Silverton et al. p. 28).

As the largest health profession, nursing has a significant impact on the delivery of health care in this country. In order to adequately ascertain the extent to which women's health issues are addressed in health professions education, the nursing education curriculum

needed to be examined. In 1998, the American Association of Colleges of Nursing (AACN) undertook a project to describe the curriculum content related to women's health included in entry-level baccalaureate nursing programs. The project was initiated in collaboration with and support from the HRSA's Division of Nursing, HRSA's Office of Women's Health, the NIH ORWH, the National Institute of Nursing Research, and the DHHS/OWH. The project was designed to build on the work previously done on women's health curricular content in medical and dental schools and to offer recommendations for integrating women's health content into entry-level baccalaureate nursing education. In order to obtain the data needed for this description, the AACN assumed responsibility for designing and implementing an entry-level baccalaureate curriculum survey.

BACKGROUND

Nursing and Women's Health

Members of the nursing profession have a long tradition of providing health services to women. From the inception of modern nursing to the present, nurses have been concerned about promoting the health of women and their families. A majority of nurses are women and thus well informed about women's health issues both as providers and consumers of health care. As early as 1912, when Lillian Wald founded the United States Children's Bureau, and 1922 when Margaret Sanger's work led to the founding of the American Birth Control League, nurses and the nursing profession have had a major role in the advancement of women and women's health (Schorr, 1999). Historically, nursing, like medicine and dentistry, viewed women's health as synonymous with reproductive health. As early as 1973, however, nursing became critical of this view (McBride & McBride, 1981) and began to redefine women's health as encompassing the entire life span of women and including health promotion, maintenance, and restoration (Expert Panel On Women's Health, 1997). Sex/gender are key variables in understanding how forces such as social roles, economic status, access to health resources, experiences of health and illness, and interactions with the health care system affect women's health (Grayson, 1999).

In 1995 the American Academy of Nursing (AAN), an organization of distinguished leaders in nursing who have major roles in transforming the health care system to optimize public well being, established an Expert Panel on Women's Health. The Panel studied "the need for transformative change in women's heath services and provided recommendations to facilitate such change in the current system of heath care and in nursing education, practice, and policy so that women's heath needs may be met more effectively" (AAN Writer's Group of Expert Panel on Women's Health, 1997). The report of the Expert Panel, published early in 1997, is a landmark document that stresses the importance of recognizing that women's health requires more than a biomedical view and must be looked at in light of economic, social, political, and environmental factors. The report describes a comprehensive, life-span vision of health care for women. In addition, the report identifies health care issues for young girls, adolescents, young adults, midlife women, and women in old age and underscores the needs of women for comprehensive care across all life stages, a range of services, and access to a range of

providers. Recognizing the significant contributions nursing can make, the report recommends the importance of nursing education to strengthen the emphasis on women's health and women's health care throughout undergraduate nursing curricula (AAN Writer's Group of Expert Panel on Women's Health, 1997; See Appendix B).

Baccalaureate Nursing Education

Education for professional nursing practice takes place at the baccalaureate level. New realities of health care require nurses to master complex information, coordinate a variety of care experiences, use technology for health care delivery and evaluation, and assist patients with managing an increasingly complex system of care (AACN, 1998). In 1986 the American Association of Colleges of Nursing (AACN) published the *Essentials of College and University Education for Professional Nursing*, the first national effort to define the essential knowledge, values, and professional behaviors expected of the baccalaureate-nursing graduate. This document "served as a framework for baccalaureate nursing education and was used by thousands of baccalaureate nursing educators to develop, define, and revise nursing curricula" over a 10-year period (AACN, 1998, p. 1).

In 1995, due to the major changes that had occurred in the health care system, AACN undertook a major initiative to revise the *Essentials*. *The Essentials of Baccalaureate Education for Professional Nursing Practice* (1998) is the result of a national consensus-building process and represents a major re-visioning of the role and education of baccalaureate-prepared nurses to meet the needs and realities of the present and future health care system. Professional values, core competencies, core knowledge, and the role of the baccalaureate-prepared professional nurse are described. Core competencies and core knowledge, particularly as they relate to women's health, are included in Appendix E.

The three primary roles of nurses, as defined in the AACN *Essentials* document, are:

- providers of care;
- designers, managers, and coordinators of care; and
- members of a profession.

As providers of care, "nurses provide care to an increasingly diverse population. Essential to the care of diverse populations is enhanced knowledge and sensitivity to such variables as age, gender, culture, race, religion, socioeconomic state, and lifestyle choice" (AACN, 1998, p. 5). Specific women's health competencies and knowledge necessary for baccalaureate nursing education have not been delineated by any professional nursing organization.

The National Advisory Council on Nurse Education and Practice (NACNEP), in the 1996 *Report to the Secretary of the Department of Health and Human Services on the Basic Registered Nurse Workforce*, recommended that at least two-thirds of the nurse workforce hold baccalaureate or higher degrees in nursing by the year 2010 (NACNEP, p. 9). Of the over 2.5 million nurses estimated to have licenses to practice as a [registered nurse] in 1996, approximately 32 percent held a baccalaureate degree, and an additional

10 percent held a master's or doctoral degree (Moses, p. 7). The highest education preparation of the remaining nurse workforce was at the associate degree or diploma level.

According to AACN's *1998-1999 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing*, there were 77,679 students enrolled in baccalaureate entry-level programs (n=428) with an additional 35,734 students enrolled in RN-to-baccalaureate programs. Graduations, between August 1997 and July 1998, from entry-level baccalaureate programs totaled 27,137 with a total of 38,164 graduating from all baccalaureate nursing programs (Berlin, Bednash, & Hosier, 1999). With the increasing complexity of the health care system, nurses, particularly baccalaureate-prepared nurses, play a significant role in meeting the health care needs of this country's population. In addition, with the increasing size, increasing diversity, and aging of the female population, professional nurses must be prepared to address the needs of women across the entire life span.

Graduate Nursing Preparation in Women's Health

Nursing specialization in women's health occurs at the graduate level. Advanced practice nurses prepared at the graduate level with specialization in women's health are prepared in primarily one of three practice roles: the obstetrical/gynecologic (ob/gyn) or women's health nurse practitioner, the certified nurse-midwife, or the clinical nurse specialist with specialization in women's health. Graduates of these advanced practice nurse programs serve not only as clinicians but may teach in baccalaureate nursing programs both in the classroom and in the clinical setting.

In the late 1960s the preparation of the obstetrical/gynecologic nurse practitioner occurred primarily in certificate or post-basic nursing education programs. As the recognition of marked inequities in women's health care in the United States increased, these programs evolved into master's level ob/gyn and women's health nurse practitioner programs (WHNP). Curricula expanded and today these advanced practice nurses are prepared to deliver specialized care to women throughout the life span. Nursing practice competencies in women's health, client care, nurse-client relationships, health education and counseling, professional role, managing health care delivery, and quality of care have been delineated along with guidelines for content areas to be included in the curriculum (Appendix D, The Association of Women's Health, Obstetric and Neonatal Nurses, 1996). As of 1998, the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC) had certified 9,327 WHNP's to practice (NCC, 1999).

A certified nurse-midwife (CNM) is a primary care provider for uncomplicated maternity, newborn, and well-woman gynecologic care. In 1931, the first formal education program to prepare nurse-midwives was developed. Since 1955, the American College of Nurse-Midwives (ACNM) has established standards for the education, certification, and practice of certified nurse-midwives. In order to be certified, individuals

are required to graduate from an accredited nurse-midwifery education program[1], be licensed as a registered nurse (RN), and successfully complete the national certification exam. Nurse-midwifery practice includes services to healthy women and their babies in the areas of prenatal care, labor and delivery management, postpartum care, normal newborn care, family planning, well-woman gynecology, preconception care, interconceptional care, and counseling in health maintenance and disease prevention. Currently, there are 45 ACNM accredited nurse-midwifery education programs in the United States. Forty of these programs offer a master's degree. Most certificate-level programs are linked with master's degree granting programs for a graduate degree completion option (ACNM, July 2000). As of January 1999, 8,026 nurse-midwives had been certified to practice by American College of Nurse-Midwives Certification Council (ACC) (ACNM, March 2000). All ACNM-accredited educational programs prepare nurse-midwives to meet the Competencies for Basic Nurse-Midwifery Practice (ACNM, 1997) (see Appendix E).

Preparation for providing women's health care also occurs in master's level education programs for adult, family, psychiatric and mental health, and geriatric nurse practitioners and clinical nurse specialists' programs with an emphasis on women's health. The extent of women's healthcare content in these other advanced practice nursing programs has not been as clearly delineated as the content in the specialty women's health nurse practitioner programs. However, these other advanced practice graduate nursing programs do represent a significant contribution to preparing health care professionals who provide health care for women.

NURSING SCHOOL BACCALAUREATE CURRICULUM SURVEY

Purpose

In August-September 1999, the American Association of Colleges of Nursing (AACN) conducted a survey on Women's Health in the entry-level baccalaureate nursing school curriculum. The purpose of the survey was to determine what is currently taught regarding women's health in the 521 schools of nursing that offer entry-level baccalaureate nursing education programs. Additionally, the survey addressed: (a) whether the content was included in the required or elective curriculum; (b) how the material was presented (as a lecture, in a small group discussion or seminar, in clinical practicum, or as a self-study); and (c) by which disciplines or specialties the material was taught.

Design of the Survey

In December 1998, AACN convened a Women's Health Advisory Group to provide advice and guidance for the Women's Health Baccalaureate Nursing Curriculum Project. The charge to the group was to provide feedback on the conceptual approach, analytical framework, and interpretation of results for the curriculum advisory group project. Representatives from nine national nursing organizations and five Federal

[1]Individuals who graduate from an ACNM accredited (non-nursing) midwifery program may now sit for the certification exam and receive the credential certified midwife (CM).

agencies/offices with an interest in women's health were invited to participate in the project. In addition, the Association of American Medical Schools and the American Association of Dental Schools were invited to appoint a representative who had participated in their respective discipline's women's health curriculum surveys. A list of the Advisory Group members is included as Appendix F. A one-day meeting was held in Washington, D.C. to reach consensus on a definition of women's health, define the target population, and discuss the survey design and content. The Advisory Group provided additional consultation throughout the project via the mail and telecommunications.

Definitions

Women's Health. The Advisory Group considered and discussed several definitions of women's health including the Public Health Service definition, the WHO definition, the American Academy of Nursing 1996 definition, and a definition written by Taylor and Woods and proposed by the Association of Women's Health, Obstetric, and Neonatal Nurses (AWOHNN, 1996).

For the purpose of this project the following working definition was agreed to by the Advisory Group:

> Women's health refers to health and illness issues that are unique to or more prevalent or serious in women, have causes or manifestations specific to women, have outcomes or intervention processes specific to women, and occur across the life span and within the context of women's lives. Such context includes but is not limited to:
>
> - Environment
> - Social status
> - Economic class
> - Political belief and/or affiliation
> - Ethnicity
> - Cultural background
> - Developmental stage
> - Biologic and/or genetic makeup
> - Spirituality

Sex and Gender. In the social sciences, "sex" and "gender" usually describe conceptually distinct approaches to understanding difference. "Sex" denotes biologically based differences, male or female. "Gender" indicates culturally and socially shaped variations between men and women (or between notions of masculinity and femininity), those qualities that are understood to be the result of cultural and social processes that constitute a person as a man or woman (Fishman, Wick, & Koenig, 1999, p.15).

Unfortunately, the biomedical literature often uses these terms as synonyms, which has serious implications for research, clinical practice, and treatment, and for understanding the nature of the health outcomes and status differences that are investigated. This distinction affects the equitable treatment of women in biomedical research and clinical practice in that distinctions need to be taken into account in analyzing states of wellness and disease that women share with men and those that they do not.

Scope of Survey

The intent of the health professional curriculum projects was to examine entry-level professional education. Therefore, in order to mirror the medical and dental school curriculum surveys, it was agreed that the scope of the survey should be baccalaureate nursing education and should include only those baccalaureate nursing programs that prepare individuals at the entry level. Although the three health professional curriculum surveys - nursing, medicine, and dentistry - examined entry-level professional education, the nursing curriculum survey examined baccalaureate education and not graduate professional education as did the medical and dental surveys. Nurses prepared at the graduate level, particularly those with a specialty in women's health (certified nurse-midwives, women's health nurse practitioners, and clinical nurse specialists with a focus on women's health), have a significant impact on women's health care in the U.S. However, the examination of women's health content in graduate nursing education programs would entail a separate curriculum survey; and, therefore, was beyond the scope of this women's health care curriculum project.

In order to include all entry-level baccalaureate nursing programs, the following types of nursing programs were included in the population (Berlin, Bednash, & Hosier, 1999, p. vii). All eligible schools (both AACN member schools and non-member schools) were sent the questionnaire.

Generic (Basic or Entry-Level) Baccalaureate. A program of instruction that admits students with no previous nursing education and requires at least four but not more that five academic years of full-time equivalent college academic work, the completion of which results in a baccalaureate nursing degree (e.g., BSN, BS, BA, etc.)

Accelerated BSN for non-nursing college graduates. A program that admits students with baccalaureate degrees and with no previous nursing education and, at completion awards a baccalaureate degree in nursing. "Accelerated" programs accomplish the programmatic objectives in a shorter time frame than the traditional program, usually through a combination of "bridge"/transition courses and core courses.

LPN to BSN. A program that admits licensed practical nurses and, at completion, awards a baccalaureate degree in nursing.

RN to BSN programs were not included in the study population. RN to BSN students already are licensed as registered nurses and, in general, are not required to take the same clinical and didactic courses so they may not be receiving the same women's health content and experiences.

Survey Design

The medical and dental school curriculum surveys provided the basic format for the design of the nursing curriculum survey. In order to allow comparison of data among the nursing, medical, and dental school curriculum surveys, format of the survey and

appropriate content areas were left relatively intact. Some specific questions and content areas were reworded, added, or deleted in order to make the survey and approach relevant to baccalaureate nursing education and holistic nursing practice.

An introductory section explored whether schools have a separate office/program responsible for ensuring the integration of women's health and sex/gender-related issues into the curriculum; and whether there are specific mechanisms to assist faculty in increasing their competence in women's health and incorporating women's health issues into their teaching. This section also solicited information regarding the number of faculty with expertise in women's health, the existence of a graduate program with a concentration in women's health, and whether there was a women's health care center within the school or on campus of the institution. The respondent also was asked to rate whether the baccalaureate nursing curriculum at his/her school placed a major, minor, or no emphasis on women's health. In designing the survey, a great deal of discussion surrounded various methods of determining the degree of emphasis placed on women's health within the baccalaureate nursing curriculum. Estimating the amount of time spent presenting or discussing content within the various courses or examining syllabi and objectives of courses in which women's health content was taught were discussed as possible methods of determining emphasis. However, the subjectivity, complexity, and time required to collect and analyze such data precluded such approaches or methods within the framework of this study.

The remainder of the survey covered 10 broad content areas related to women's health:

1. General topics
2. Biologic considerations
3. Development and psychosocial issues
4. Approaches to health behaviors/health promotion in women
5. Sexual and reproductive functioning at various life stages
6. Etiology, prevalence, course, treatment and prevention of common health problems of the reproductive tract
7. Etiology, prevalence, course, treatment, and prevention of other medical conditions specifically in women
8. Health assessment and teaching
9. Selected topics; and
10. Legal and ethical issues

One hundred seventeen specific content items are addressed under these 10 content areas of women's health. The section on selected topics includes such items as women's health and economic issues, women's health and spirituality issues, lesbian health issues, health issues for women with disabilities, effects of gender discrimination and sexual harassment, and gender specific communication styles. A copy of the complete survey is included in Appendix G.

The broad content areas encompass basic science topics, developmental and psychosocial issues, gender-specific approaches to health behaviors, sexual and reproductive function, common health conditions, and assessment techniques. However, the topics in each content area are not inclusive. For example, nursing curricula, traditionally, have included didactic and clinical courses on maternity care and care of women during

pregnancy, delivery, and postpartum as distinct parts of the curriculum. Therefore, many specific topics related to reproduction and pregnancy were not included in the survey instrument. This approach was consistent with that used for the medical school curriculum survey (HRSA, 1996, p.13). Maternity care continues to be an integral component of the expanded concept of women's health and life span issues.

For each specific content area, information regarding the primary formats used to present the content and those individuals responsible for teaching the content or topics also was asked. The primary formats were lecture, small group discussion/seminar, clinical practicum, and self-study. More than one response could be selected since content may be taught in more than one course and may be taught in both didactic and clinical sessions. Content that is addressed through a clinical practicum would provide direct patient care or hands-on experience in that area. Individuals responsible for teaching the content included nurse faculty with advanced preparation in women's health, other nursing faculty, physicians, psychologists, pharmacists, and others (e.g. nutritionists, social workers, or physiologists).

Conduct of the Survey

The survey, cover letter, and self-addressed stamped envelope were sent in August 1999 by AACN to the deans/directors of the 521 schools in the United States that had one or more of the entry-level baccalaureate nursing education programs as defined above. A copy of the cover letter and survey are included in Appendix G. The dean/director was asked to forward the survey to the individual most knowledgeable about the baccalaureate nursing curriculum.

In an attempt to optimize the response rate, a follow-up electronic message was sent after one month and again after two months to the dean or director of those schools of nursing that had not returned the survey. Non-respondents were asked to request a duplicate copy of the survey if the original was not available. Forty-four additional surveys were requested and sent out. In addition, an announcement was made during the business session at the AACN 1999 Fall Annual Meeting at which 297 deans were in attendance. Three hundred thirty-four surveys were completed and returned, an overall response rate of 64%.

The medical school curriculum survey included two phases. In 1994, a three-page questionnaire was sent to the 142 medical schools in the United States and Canada as part of the Association of Medical Colleges (AAMC) annual Medical School Curriculum Directory. The overall response rate to this first survey was 82%, with an 85% and 63% response rate from the U.S. and Canadian schools respectively (HRSA, 1996, p. 6). In 1995, a more comprehensive curriculum survey, similar to the one used for the nursing and dental curriculum reports and for which comparisons among the nursing, dental, and medical school responses are presented later in this report, was mailed to 142 medical schools in the U.S. and Canada. The overall response rate for the second survey was 63%, with a 67% and 25% response rate from the U. S. and Canadian schools, respectively (Health Resources and Services Administration, 1996, p. 13). The dental school curriculum survey was sent to 64 dental schools in the U.S. and Canada and had

an overall response rate of 88%, with 94% of the U.S. and 50% of the Canadian schools responding (Silverton & others, 1998, p. 7). Due to the very large number of nursing schools (n=521) with entry-level baccalaureate programs, individual contacts were not made as was done with the medical and dental school curriculum surveys to increase the response rate. The length and complexity of the survey also limited the response rate. The respondents to the nursing school curriculum survey, however, do reflect the entire population as is shown in the next section.

RESULTS AND DISCUSSION

Comparison of Respondents to Non-Respondents

Of the 521 surveys mailed to institutions with entry-level baccalaureate nursing programs, 334 surveys were returned for an overall response rate of 64%. A comparison of the characteristics of the respondent and non-respondent schools are shown in Table 1[2]. Chi Square analyses were used to compare the respondent and non-respondent schools. No significant differences at the p=0.05 level were found when looking at Carnegie classification (p=0.104), geographic region of the country (p=0.710), public/private status (p=0.258), types of nursing programs offered[3] (p=0.071), and enrollment size (p=0.08). The comparison variables represent the major demographic characteristics of schools. The Carnegie Classification of higher education groups colleges and universities according to their missions, e.g. baccalaureate, master's, doctoral, and research institutions. The only characteristic on which there was a significant difference between the respondent and non-respondent schools was that respondents were more likely to be part of an Academic Health Center (AHC) than non-respondents (p=0.006).

[2]If a school did not respond to the Fall 1998 annual enrollment and graduation survey, information is not available in the current AACN Institutional Data System. The 1998 database represents the population used for this survey.

[3]Type of nursing programs offered was divided into baccalaureate, baccalaureate/master's, and baccalaureate, master's and doctoral program.

Table 1: Comparison of respondents and non-respondents on six characteristics

Characteristic	Respondents	Non-respondents	Total Population
Public/Private			
Public	152 (51%)	67 (45%)	219 (49%)
Private	147 (49%)	83 (55%)	230 (51%)
Total	299 (100%)	150 (100%)	449[4]
(p=0.258)			
Carnegie Classification			
Bacc I & II	63 (19%)	48 (26%)	111 (21%)
Master's I & II	152 (46%)	90 (48%)	242 (46%)
Doctoral I & II	38 (11%)	17 (9%)	55 (11%)
Research I & II	49 (15%)	15 (8%)	64 (12%)
Other	32 (10%)	17 (9%)	49 (9%)
Total	334 (100%)	187 (100%)	521
(p=0.104)			
Geographic Region			
Northeast	72 (22%)	39 (21%)	111 (21%)
South	119 (36%)	75 (40%)	194 (37%)
Midwest	105 (31%)	51 (27%)	156 (30%)
West	38 (11%)	22 (12%)	60 (12%)
Total	334 (100%)	187 (100%)	521
(p=0.710)			
Types of Nursing Programs Offered			
Baccalaureate only	105 (35%)	67 (45%)	172 (39%)
Baccalaureate & Master's	143 (48%)	65 (44%)	208 (47%)
Baccalaureate, Master's & Doctoral	50 (17%)	16 (11%)	66 (15%)
Total	298 (100%)	148 (100%)	446[5]
(p=0.071)			
Enrollment Size			
<250	155 (52%)	91 (61%)	246 (55%)
250-500	79 (27%)	38 (26%)	117 (26%)
>500	62 (21%)	19 (13%)	81 (18%)
Total	296 (100%)	148 (100%)	444[6]
(p=0.080)			
Part of Academic Health Center			
Yes	57 (17%)	15 (8%)	72 (14%)
No	274 (83%)	172 (92%)	446 (86%)
Total	331 (100%)	187 (100%)	518[7]
(p=0.006)			

[4]Data not available on 72 schools
[5]Data not available on 75 schools
[6]Data not available on 77 schools
[7]Data not available on 3 schools

Survey Results: General Questions

Of the 334 respondents, 74 (22%) of the schools of nursing indicated they had an office of women's health or dedicated program personnel responsible for ensuring the integration of women's health and gender-related issues into the curriculum.

Table 2: Number (%) of the responding schools of nursing with a women's health office or dedicated personnel (n=334)

Have Office of Women's Health or dedicated personnel	74 (22%)
Do not have Office of Women's Health or dedicated personnel	256 (77%)
Don't know	2 (1%)
No response	2 (1%)

Sixty-eight (20%) of the schools reported they had a specific mechanism designed to assist faculty in increasing their competence in women's health and in incorporating women's health and gender-related issues into their teaching (see Table 3.) Of these schools, only 29 (43%) also had an Office of Women's Health or dedicated program personnel responsible for ensuring the integration of women's health into the baccalaureate curriculum. Six (8%) schools said they utilized a special curriculum committee or had a faculty member with women's health expertise participate in the curriculum planning. Fifty (74%) schools reported some type of continuing education for faculty, such as workshops, conferences, training, and funding specifically for continuing education. Other examples cited for integrating women's health into the curriculum included a women's health grant, a women's health nurse practitioner (WHNP) program, a center for women's health, and clinical practice.

Table 3: Number (%) of the responding schools with a mechanism to assist faculty in increasing their competence in women's health and in incorporating women's health and gender-related issues into their teaching (n=334)

Have specific mechanisms	68 (20%)
Do not have specific mechanisms	263 (79%)
Don't know	1 (1%)
No response	2 (1%)

The existence of a graduate nursing program in women's health, a Federally funded Center of Excellence, or a women's health care center within the school or on campus also was determined. The responses to these four questions are shown in Tables 4 & 5.

Table 4: Number (%) of the responding schools with a women's health care center within the school of nursing or on campus

	WH Care Center within school of nursing	**WH Care Center within institution or on campus**
Yes	17 (5%)	76 (23%)
No	315 (94%)	250 (75%)
Don't know	0 (0%)	6 (2%)
No response	2 (1%)	2 (1%)
Totals:	334 (100%)	334 (100%)

In 1996, the DHHS/OWH established National Centers of Excellence in Women's Health. Their purpose was to establish and evaluate models of health care that "unite women's health research, medical training, clinical care, public health education, community outreach, and the promotion of women in academic medicine around a common mission – to improve the health status of diverse women across the life span" (OWH, Dec. 3, 1999). Nine of the 18 institutions that had National Centers of Excellence in Women's Health at the time of the survey do have entry-level baccalaureate nursing programs and did respond to the survey; therefore, they were included in the baccalaureate nursing curriculum population. Of the other nine institutions that had National Centers of Excellence in Women's Health, one did not respond to the survey and eight either did not have a school of nursing or did not have an entry-level baccalaureate nursing program.

Table 5: Number (%) of responding schools that have a Federally funded Center of Excellence in Women's Health

Have Center of Excellence	9 (3%)
Do not have Center of Excellence	303 (91%)
Don't know	18 (5%)
No response	4 (1%)
Total:	334 (100%)

Sixty-two (19%) of the 334 responding schools offered one or more graduate programs with a specialty in women's health. Twenty-two (35%) of these schools offered two or more graduate programs with a specialty in women's health. The breakdown of type of graduate program with a specialty in women's health is shown in Table 6.

Table 6: Number of schools that offer a graduate program with a specialty in women's health by type of program

Type(s) of Graduate Program	Number of Schools Offering
Women's health nurse practitioner (WHNP) only	21
Certified nurse-midwife (CNM) only	10
Clinical nurse specialist with women's health specialty (CNS with WH specialty) only	8
WHNP & CNM	12
WHNP & CNS with WH specialty	6
WHNP, CNM & CNS with WH specialty	4
Unspecified	1
Total:	62

Using the project's definition of women's health, each school was asked to rate the degree of emphasis placed on women's health within the baccalaureate nursing curriculum. (Refer to page 5 for the operational definition used for this survey.) Fifty (15%) schools said their baccalaureate nursing curriculum placed a major emphasis on women's health; and 242 (72%) schools said there was a minor emphasis placed on women's health (See Table 7).

Table 7: Based on the survey's definition of women's health, the number (%) of schools that rated the degree of emphasis placed on women's health in the baccalaureate nursing curriculum

How schools rated WH emphasis in baccalaureate nursing curriculum	**Number (%) of schools**
Major emphasis	50 (15%)
Minor emphasis	242 (72%)
Unclear or no emphasis	38 (11%)
No response	4 (1%)
Total:	334 (100%)

Cross tabs and Chi Square analyses were performed between the five variables described above and the degree of emphasis placed on women's health within the baccalaureate nursing curriculum. The degree of emphasis placed on women's health in the baccalaureate nursing curriculum and the variables listed above are shown in Table 8. A significant association (Chi Square, $p < 0.0001$) was found between the existence of an Office of Women's Health or dedicated program personnel responsible for ensuring the integration of women's health and gender-related issues into the curriculum and the emphasis placed on women's health in the baccalaureate nursing curriculum. Those schools that have an Office of Women's Health or dedicated women's health personnel within the school of nursing indicated they place a greater degree of emphasis on women's health within the baccalaureate nursing curriculum than do those schools that do not have dedicated women's health personnel. It is not known whether the existence of an Office of Women's Health or dedicated program personnel is the result of an increased emphasis or the reverse. A significant association (Chi Square, $p < 0.0001$) also was found between the existence of a graduate program in women's health and the emphasis placed on women's health within the baccalaureate curriculum. Schools that had a graduate program with a major in women's health indicated they placed a greater emphasis on women's health within the baccalaureate nursing curriculum than did those who did not have a graduate program in women's health.

Table 8: Cross Tabs and Chi Square Analyses between the Degree of Emphasis Placed on Women's Health in the Undergraduate Nursing Curriculum and Five Institutional Characteristics

Degree of Emphasis Placed on Women's Health in Undergraduate Nursing Curriculum

	Major emphasis Yes (#,%)	Major emphasis No (#,%)	Minor emphasis Yes (#,%)	Minor emphasis No (#,%)	No emphasis Yes (#,%)	No emphasis No (#,%)	Totals Yes (#,%)	Totals No (#,%)	p value
Schools of nursing with Office of Women's Health or dedicated program personnel	21(8%)	29(9%)	49(16%)	189(58%)	3(<1%)	35(11%)	73(22%)	253(78%)	p<0.0001
Women's health care center within school of nursing	4(1%)	44(13%)	11(3%)	231(70%)	2(<1%)	36(11%)	17(5%)	315(95%)	p=0.557
Women's health care center on campus	13(4%)	34(11%)	51(16%)	187(58%)	12(4%)	25(8%)	76(24%)	246(76%)	p=0.265
Federally funded center of excellence in women's health	2(<1%)	43(14%)	4(1%)	224(73%)	3(1%)	32(10%)	9(3%)	299(97%)	p=0.087
Schools of nursing offering graduate program with major in women's health	19(6%)	31(10%)	34(11%)	202(63%)	9(3%)	27(8 %)	62(19%)	260(81%)	p<0.0001

Healthy People 2000, published in 1991, laid out the health promotion, disease prevention objectives for the United States. Seven areas or objectives are cited in the index under women. These include: clinical breast exam and mammogram, iron deficiency, pap testing, physical abuse by male partners, prevention of osteoporosis, rape and attempted rape, and shelters (U.S. DHHS, PHS, 1991, p. 692). As major objectives for the Nation's health, these should have had a significant impact on health professional education over the last decade. Of the 334 responding schools, 240 (72%) indicated the *Healthy People 2000* objectives were used in the curriculum planning or review process; 69 (21%) said the objectives were not used; 18 (5%) said they did not know; and 7 (2%) gave no response.

Table 9: Number (%) of schools using Healthy People 2000 objectives in the curriculum planning or review process

Did your school use the *Healthy People 2000* objectives in the curriculum planning or review process?	**Number (%) of schools**
Yes	240 (72%)
No	69 (21%)
Don't know	18 (5%)
No response	7 (2%)
Total:	334 (100%)

Survey Results: Women's Health Content

Results regarding women's health curriculum content included in entry-level baccalaureate nursing programs are presented in this section. Also, whether the content was taught in required or elective courses, the primary formats used to present the information, and who was primarily responsible for teaching the content are addressed.

As a general caveat, schools reported that the survey was extremely long and tedious to complete. Data are self-reported by school of nursing faculty. Some respondents indicated that it was necessary to have the survey completed by several individuals since the content in question was frequently taught in a number of courses that spanned the entire four-year curriculum. Also, the need to differentiate topics as they specifically relate to women as opposed to the population as a whole presented difficulties for many completing the survey. Due to the size of the population and number of respondents, it was not possible to follow-up with telephone interviews to complete missing data; however, follow-up telephone or email contacts were made when necessary to clarify conflicting responses. Therefore, a number of individual items have missing data; however, the data that are presented accurately reflects the responses of the entry-level baccalaureate nursing education programs.

As a guide to the overview of results, the survey was divided into the following ten broad content areas (117 items total):

1. General topics (4 items)
2. Biologic considerations (8 items)
3. Development and psychosocial issues (17 items)

4. Approaches to health behaviors/health promotion in women (18 items)
5. Sexual and reproductive functioning at various life stages (7 items)
6. Etiology, prevalence, course, treatment and prevention of common health problems of the reproductive tract (6 items)
7. Etiology, prevalence, course, treatment, and prevention of other medical conditions specifically in women (19 items)
8. Health assessment and teaching (17 items)
9. Selected topics (16 items); and
10. Legal and ethical issues (5 items).

The survey consisted of 117 women's health and sex/ gender-related topics that were divided among 10 content areas. In designing the survey, specific items were added and/or reworded to reflect nursing as a discipline. However, the primary format of the survey and content areas where relevant were left unchanged in order to allow comparison of women's health content taught across nursing, medicine, and dentistry. The individual items included under each content area can be found in the Questionnaire, Appendix G.

Some schools indicated that content was taught in both required and elective courses; therefore, the percentages across topics do not equal 100 percent. The percentages are calculated based on the total number of schools responding to the survey (n=334). Where data was missing these are indicated as not reported.

General Topics

The content areas examined under "General Topics" addressed issues focusing on race/ethnicity/culture, spirituality and health beliefs, and poverty/socioeconomic status and the impact on health status across the life span. Table 10.1 presents the frequencies with which each topic was covered by the 334 responding schools in the entry-level baccalaureate nursing curriculum either in required and/or elective courses.

Table 10.1: Number (%) of responding schools of nursing that taught each topic in the "General Topics" category according to type of course (n=334)[8]

General Topics	Required Course Content	Elective	Not Offered	Not Reported
The impact of gender on health issues across the life stages	305 (91%)	20 (6%)	7 (2%)	4 (1%)
The impact of race /ethnicity/ culture on health status, health beliefs and behaviors, and health care utilization	327 (98%)	12 (4%)	0 (0%)	2 (1%)
The impact of spirituality on health status, health beliefs and behaviors, and health care utilization	314 (94%)	15 (4%)	11 (3%)	2 (1%)
The impact of poverty/ socioeconomic status on health status and access to health care	323 (97%)	9 (3%)	2 (1%)	4 (1%)

[8]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

Nearly all (>90%) of the responding schools do address the areas of gender, race/ethnicity/culture, spirituality, and poverty either in a required course or an elective course. Only three percent or less of the responding schools indicated they did not cover the content anywhere in the baccalaureate nursing curriculum and only four percent or less either did not cover the content or did not report whether this content was included in the curriculum.

Biologic Considerations

The topics in this broad area generally reflect content taught in the basic science courses, e.g. anatomy/physiology, pharmacology, and growth and development. A majority of the schools did include all of the topic areas included in this category. The one area included by the fewest number of schools is "gender differences in pharmacokinetics of drugs." Thirty-nine (12%) of the schools indicated they did not include this content and 18 (5%) gave no response.

Table 10.2: Number (%) of responding schools of nursing that taught each topic in the "Biologic Considerations" category according to type of course[9] (n=334)

Biologic Considerations	Required Course Content	Elective	Not Offered	Not Reported
Normal and abnormal female anatomy & physiology	325 (97%)	6 (2%)	3 (1%)	7 (2%)
Female reproductive biology	322 (96%)	8 (2%)	4 (1%)	7 (2%)
Genetic influences on health risks of women	306 (92%)	11 (3%)	20 (6%)	4 (1%)
Sex/gender differences in pathogenesis of disease and disease mechanisms	296 (89%)	11 (3%)	28 (8%)	7 (2%)
Sex/gender differences in epidemiology of disease and disease rates	298 (89%)	11 (3%)	20 (6%)	11 (3%)
Gender differences in pharmacokinetics of drugs	271 (81%)	11 (3%)	39 (12%)	18 (5%)
Sex/gender differences on development across the lifespan	312 (93%)	13 (4%)	14 (4%)	4 (1%)
Sex/gender differences in biologic aging process	300 (90%)	15 (4%)	21 (6%)	7 (2%)

Developmental and Psychosocial Issues

This broad content area included both the physiologic and psychosocial effects of reproductive hormones across the lifespan, gender identification and sexual orientation, consequences of traumas experienced by women, and the influence of sex/gender on a number of psychological disorders frequently associated with women in our society. Ninety-eight percent of respondents stated that domestic violence was included either in required coursework and/or elective coursework. Ninety-seven percent of programs

[9]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

included childhood sexual/physical/emotional abuse in the curriculum. In addition, 95 percent of responding schools indicated that rape was included in the baccalaureate nursing curriculum. The inclusion of childhood abuse, domestic violence, and rape in such a large percentage of the baccalaureate nursing curricula is particularly significant since a victim's first encounter with the health care system may be with a nurse. Also, the nurse's role in counseling and supporting survivors is critical.

Although included in the required curicula by the majority of schools, criminal victimization other than childhood abuse, domestic violence or rape (67%), discrimination/oppression (69%), and workplace harassment (60%) were among the lowest percentages of required school curricula.

Table 10.3: Number (%) of responding schools of nursing that taught each topic in the "Developmental and Psychosocial Issues" category according to type of course[10] (n=334)

Developmental and Psychosocial Issues	Required Course Content	Elective	Not Offered	Not Reported
Milestones in the developmental process of women	277 (83%)	19 (6%)	29 (9%)	14 (4%)
Physiologic effects of reproductive hormones across the lifespan of females	313 (94%)	14 (4%)	11 (3%)	6 (2%)
Psycho/social effects of reproductive hormones across the lifespan of females	291 (87%)	17 (5%)	27 (8%)	9 (3%)
Integrated biologic/psycho/social effects of reproductive hormones across the lifespan of females	284 (85%)	17 (5%)	31 (9%)	12 (4%)
Pubertal development and changing health issues in young women	304 (91%)	17 (5%)	13 (4%)	10 (3%)
Gender identification and sexual orientation	269 (81%)	22 (7%)	40 (12%)	14 (4%)
Impact of societal role expectations on women's health	267 (80%)	35 (10%)	35 (10%)	9 (3%)
Health consequences of traumas experienced by women:	---	---	---	---
Childhood sexual/physical/ emotional abuse	315 (94%)	17 (5%)	5 (1%)	6 (2%)
Domestic violence	318 (95%)	23 (7%)	4 (1%)	4 (1%)
Rape	307 (92%)	20 (6%)	7 (2%)	10 (3%)
Other criminal victimization	224 (67%)	14 (4%)	77 (23%)	23 (7%)
Discrimination/oppression	230 (69%)	18 (5%)	75 (22%)	16 (5%)
Workplace harassment	201 (60%)	21 (6%)	97 (29%)	18 (5%)
Influence of sex/gender on the following conditions:	---	---	---	---
Anxiety disorders (panic/phobias)	305 (91%)	10 (3%)	12 (4%)	13 (4%)
Depressive syndromes	308 (92%)	10 (3%)	10 (3%)	13 (4%)
Eating behaviors/disorders	313 (94%)	9 (3%)	9 (3%)	9 (3%)
Addictive behaviors/disorders	304 (91%)	10 (3%)	12 (4%)	14 (4%)

Approaches to Health Behaviors/Health Promotion in Women

Nursing traditionally has included health promotion as a strong component of practice and education. Nine of the 18 content areas included under "Approaches to Health Behaviors/Health Promotion in Women" were included in over 90 percent of schools' required coursework. All except two of the areas listed under this broad content area are included in over 80 percent of the schools' required course work. The two areas not included as frequently were physical fitness and weight management (76%) and nutrition (79%). However, only 46 (14%) and 18 (5%) schools, respectively, indicated this content was not included anywhere in the baccalaureate nursing curriculum; and only 60

[10]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

(18%) and 25 (7%) of the schools indicated the content was not included in the curriculum or gave no response.

Table 10.4: Number (%) of responding schools of nursing that taught each topic in the "Approaches to Health Behaviors/Health Promotion in Women" category according to type of course[11] (n=334)

Approaches to Health Behaviors/Health Promotion in Women:	Required Course Content	Elective	Not Offered	Not Reported
Adaptation to stress	300 (90%)	17 (5%)	19 (6%)	8 (2%)
Physical fitness and weight management	254 (76%)	26 (8%)	46 (14%)	14 (4%)
Nutrition	263 (79%)	16 (5%)	18 (5%)	7 (2%)
Reproductive decision-making	310 (93%)	14 (4%)	11 (3%)	6 (2%)
HIV/AIDS and prevention of risk	322 (96%)	15 (4%)	3 (1%)	5 (1%)
Other STDs and prevention of risk	323 (97%)	13 (4%)	3 (1%)	6 (2%)
Intentional and unintentional self-inflicted injuries, e.g. suicide	299 (90%)	11 (3%)	18 (5%)	12 (4%)
Tobacco use and cessation	283 (85%)	13 (4%)	32 (10%)	10 (3%)
Effect of tobacco on women's health, particularly the reproductive tract and osteoporosis	280 (84%)	9 (3%)	40 (12%)	8 (2%)
Alcohol use/abuse	304 (91%)	19 (6%)	10 (3%)	12 (4%)
Prescription drug abuse	283 (85%)	22 (7%)	25 (7%)	15 (4%)
Other substance use/abuse	294 (88%)	20 (6%)	16 (5%)	15 (4%)
Prevalence, pathophysiology, assessment, medical/nursing management and prevention of:	---	---	---	---
Lung cancer in women	296 (89%)	15 (4%)	19 (6%)	15 (4%)
Breast cancer in women	320 (96%)	17 (5%)	4 (1%)	6 (2%)
Colorectal cancer in women	290 (87%)	15 (4%)	25 (7%)	15 (4%)
Cancers specific to women (e.g. ovarian, uterine, cervical)	314 (94%)	17 (5%)	7 (2%)	8 (2%)
Cardiovascular risk prevention and screening	313 (94%)	14 (4%)	9 (3%)	9 (3%)
Occupational/environmental health hazards	274 (82%)	19 (6%)	36 (11%)	16 (2%)

Sexual and Reproductive Functioning at Various Life Stages

Sexual and reproductive functioning at various life stages is included in most baccalaureate nursing programs as part of the required curricula. Over 90 percent of baccalaureate programs included six of the seven topics in the required course content and the seventh topic, "sequelae of infertility," was included in 86 percent of the schools required curricula. Only 12 percent of the schools indicated they did not teach this topic (9%) anywhere in the baccalaureate program or gave no response (3%).

[11]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

Table 10.5: Number (%) of responding schools of nursing that taught each topic in the "Sexual and Reproductive Functioning at Various Life Stages" category according to type of course[12] (n=334)

Sexual and Reproductive Functioning at Various Life Stages	Required Course Content	Elective	Not Offered	Not Reported
Normal menstruation	324 (97%)	12 (4%)	4 (1%)	4 (1%)
Contraception and fertility management	327 (98%)	15 (4%)	2 (1%)	4 (1%)
Intended/unintended pregnancy	321 (96%)	13 (4%)	4 (1%)	8 (2%)
Preconception and interconceptional health practices (getting to pregnancy in optimal health)	312 (93%)	14 (4%)	13 (4%)	6 (2%)
Use of folic acid/folate to decrease incidence of spina bifida	320 (96%)	7 (2%)	4 (1%)	9 (3%)
Sequelae of infertility	287 (86%)	16 (5%)	31 (9%)	11 (3%)
Sexuality	313 (94%)	21 (6%)	8 (2%)	7 (2%)

Etiology, Prevalence, Course, Treatment, and Prevention of Common Health Problems of the Reproductive Tract

The etiology, prevalence, course, treatment and prevention of common health problems of the reproductive tract are included in the required curricula of a majority (>85%) of the baccalaureate nursing programs. These topics traditionally are taught in greater depth in the graduate women's health programs because graduates of these programs would be responsible for the evaluation, diagnosis and possible treatment of these health problems. Over 90 percent of the baccalaureate nursing programs included three of the six topics in the required course content, and over 85 percent of the baccalaureate programs included the remaining three topics in the required coursework. Seven to nine percent of the schools indicated they did not include these three topic areas anywhere in the curriculum, and only 11–14 percent of the schools either did not include these topics in the curricula or gave no response.

[12]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

Table 10.6: Number (%) of responding schools of nursing that taught each topic in the "Etiology, Prevalence, Course, Treatment, and Prevention of Common Health Problems of the Reproductive Tract" category according to type of course[13] (n=334)

The Etiology, Prevalence, Course, Treatment, and Prevention of Common Health Problems of the Reproductive Tract:	Required Course Content	Elective	Not Offered	Not Reported
Breast health	306 (92%)	12 (4%)	15 (4%)	9 (3%)
Benign breast disorders	289 (87%)	12 (4%)	23 (7%)	17 (5%)
Endometriosis	295 (88%)	12 (4%)	22 (7%)	13 (4%)
Fibroids	283 (85%)	13 (4%)	30 (9%)	17 (5%)
Pelvic inflammatory disease	308 (92%)	12 (4%)	11 (3%)	12 (4%)
Vaginal Infections	312 (93%)	10 (3%)	5 (2%)	15 (4%)

Etiology, Prevalence, Course, Treatment, and Prevention of Conditions Specifically in Women

The content areas in this broad category include a number of health problems and conditions that occur in both men and women. Although these topics may be generally addressed in the curriculum, it was the inclusion of the topic as it specifically relates to the health of women that was covered in this section. The percentage of schools that include these content areas is lower than in the other broad content areas. However, two of the topics, osteoporosis and urinary tract infections, are included in over 80 percent of the schools' required coursework. One of the 19 topics, temporomandibular joint disease (46%), was included in less than 50 percent of the required coursework. An additional four topics: lipoprotein disorders, interstitial cystitis, fibromyalgia and chronic fatigue syndrome, and functional bowel disorders, were included in 50–60 percent of the schools' required coursework.

[13]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

Table 10.7: Number (%) of responding schools of nursing that taught each topic in the "Etiology, Prevalence, Course, Treatment and Prevention of the Following Conditions Specifically in Women" category according to type of course[14] (n=334)

The Etiology, Prevalence, Course, Treatment, and Prevention of the Following Conditions *SPECIFICALLY IN WOMEN*:	Required Course Content	Elective	Not Offered	Not Reported
Cardiovascular disease	260 (78%)	17 (5%)	40 (12%)	25 (7%)
Coronary artery disease	248 (74%)	14 (4%)	51 (15%)	29 (9%)
Stroke syndromes	216 (65%)	10 (3%)	76 (23%)	38 (11%)
Hypertension	227 (68%)	12 (4%)	68 (20%)	34 (10%)
Lipoprotein disorders	194 (58%)	9 (3%)	89 (27%)	46 (14%)
Diabetes	236 (71%)	9 (3%)	62 (19%)	34 (10%)
Obesity	216 (65%)	14 (4%)	75 (22%)	35 (10%)
Immunologic Disease (e.g., SLE,* RA,** Scleroderma)	225 (67%)	8 (2%)	65 (19%)	40 (12%)
Respiratory disorders (e.g., COPD,*** Asthma)	204 (61%)	7 (2%)	83 (25%)	45 (13%)
Osteoporosis	291 (87%)	14 (4%)	17 (5%)	20 (6%)
Osteoarthritis	226 (68%)	8 (2%)	63 (19%)	41 (12%)
Migraine/other headache disorders	201 (60%)	8 (2%)	83 (25%)	46 (14%)
Temporomandibular joint disease	153 (46%)	8 (2%)	118 (35%)	58 (17%)
Urinary incontinence	257 (77%)	14 (4%)	44 (13%)	26 (8%)
Urinary tract infection	275 (82%)	13 (4%)	29 (9%)	24 (7%)
Interstitial cystitis	193 (58%)	9 (3%)	91 (27%)	46 (14%)
Fibromyalgia and chronic fatigue syndrome	185 (55%)	9 (3%)	96 (29%)	47 (14%)
Inflammatory bowel disorders (e.g. Crohn's, ulcerative colitis)	203 (61%)	5 (1%)	83 (25%)	45 (13%)
Functional bowel disorders	191 (57%)	5 (1%)	89 (27%)	51 (15%)

*Systemic Lupus Erythematosis
**Rheumatoid Arthritis
***Chronic Obstructive Pulmonary Disease

Health Assessment and Teaching

Health assessment and teaching is a major component of the professional nursing role. This broad category of women's health content includes those areas that relate specifically to the history taking and the application of knowledge of women's health issues to patient teaching. Sixteen of the 17 topics are included in over 80 percent of the required coursework of baccalaureate nursing programs, and 6 of these topics are included in 90 percent or more of the baccalaureate required coursework. The one topic that was not included as frequently was patient teaching and the application to nursing interventions for endometrial biopsy (63%). One topic not included or not responded to by 19 percent of the schools was "cultural competence in communicating with women" although 81 percent of the schools did include this topic in the required course content.

[14]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

Table 10.8: Number (%) of responding schools of nursing that taught each topic in the "Health Assessment and Teaching" category according to type of course[15] (n=334)

Health Assessment and Teaching	Required Course Content	Elective	Not Offered	Not Reported
Taking a reproductive history	326 (98%)	7 (2%)	3 (1%)	5 (1%)
Taking a sexual history	313 (94%)	7 (2%)	12 (4%)	6 (2%)
Obtaining history of traumatic events (e.g., domestic violence, rape, incest)	292 (87%)	9 (3%)	21 (6%)	15 (4%)
Understanding gender influences on patient/health provider relationship	271 (81%)	13 (4%)	41 (12%)	15 (4%)
Understanding cultural background influences on patient/health provider relationship	317 (95%)	7 (2%)	8 (2%)	8 (2%)
Cultural competence in communicating with women	270 (81%)	11 (3%)	39 (12%)	22 (7%)
Patient education/teaching appropriate to the age, gender, and cultural status of women	303 (91%)	8 (2%)	16 (5%)	12 (4%)
Patient teaching and the application to nursing interventions for:	---	---	---	---
Endometrial biopsy	209 (63%)	12 (4%)	77 (23%)	40 (12%)
Cervical (Pap) smears/ biopsy	274 (82%)	11 (3%)	34 (10%)	20 (6%)
HIV/AIDS in women	292 (87%)	16 (5%)	15 (4%)	20 (6%)
Other STDs in women	299 (90%)	13 (4%)	12 (4%)	19 (6%)
Domestic Violence protocol	271 (81%)	16 (5%)	27 (8%)	27 (8%)
Common diagnostic testing done during pregnancy	314 (94%)	4 (1%)	4 (1%)	14 (4%)
Assessment and symptom management issues related to:	---	---	---	---
Sleep	274 (82%)	4 (1%)	37 (11%)	22 (7%)
Fatigue	272 (81%)	4 (1%)	38 (11%)	23 (7%)
Pain	280 (84%)	4 (1%)	32 (10%)	21 (6%)
Mobility	276 (83%)	3 (1%)	33 (10%)	25 (7%)

Selected Topics

Selected topics represent a number of sex/gender-specific issues that may or may not involve direct patient care but represent issues that are extremely relevant to the health and well-being of women in today's society. Of the 16 topic areas, two were included in the required curriculum of less than 50% of the baccalaureate nursing programs, lesbian health issues (39%), and health issues for women with disabilities (47%). Two additional topics, gender-specific health care decision making and the effects of gender discrimination and sexual harassment, were included in 52% and 57% of the required coursework, respectively. However, one topic, accessing community resources sensitive

[15]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

to women's health care needs (e.g., shelters, safe houses, legal resources) was included in 93% of the required coursework of baccalaureate nursing programs.

Table 10.9: Number (%) of responding schools of nursing that taught each topic in the "Selected Topics" category according to type of course[16] (n=334)

Selected Topics	Required Course Content	Elective	Not Offered	Not Reported
Women's health issues within and across cultural/ethnic groups	243 (73%)	52 (16%)	41 (12%)	10 (3%)
Women's health and socioeconomic issues	252 (75%)	48 (14%)	35 (10%)	11 (3%)
Women's health and spirituality issues	212 (63%)	45 (13%)	65 (20%)	22 (7%)
Health issues of elderly women	279 (84%)	34 (10%)	23 (7%)	9 (3%)
Lesbian health issues	130 (39%)	41 (12%)	139 (42%)	31 (9%)
Health issues for women with disabilities	157 (47%)	30 (9%)	124 (37%)	32 (10%)
Gender specific health care decision-making	175 (52%)	38 (11%)	100 (30%)	29 (10%)
Gendered nature of health care and nursing	213 (64%)	28 (8%)	66 (20%)	33 (10%)
Gender specific communication styles	200 (60%)	32 (10%)	82 (25%)	31 (9%)
Effects of gender discrimination and sexual harassment	192 (57%)	36 (11%)	81 (24%)	33 (10%)
Women as providers, consumers, decision-makers and caregivers in families	256 (77%)	34 (10%)	34 (10%)	19 (6%)
Issues of empowerment at the individual and professional level	248 (74%)	29 (9%)	42 (13%)	23 (7%)
Homelessness of women	247 (74%)	24 (7%)	50 (15%)	22 (7%)
Loss of spouse	256 (77%)	23 (7%)	38 (11%)	28 (8%)
Loss of a child	294 (88%)	18 (5%)	17 (5%)	14 (14%)
Accessing community resources sensitive to women's health care needs (e.g., shelters, safe houses, legal resources)	309 (93%)	24 (7%)	9 (3%)	7 (2%)

Legal and Ethical Issues

Ethics, which includes the values, codes, and principles that govern decisions in nursing practice, conduct, and relationships (AACN, 1998, p. 14), is one of the Core Knowledge areas identified in *The Essentials of Baccalaureate Education for Professional Nursing Practice*. However, how these issues specifically relate to women's health is not addressed in the *Essentials* document. Over 70 percent of the responding schools include three of the topic areas: health policy implications on women's health, legal issues surrounding rights of women, and awareness of research on women and minority health, in the required course content. Over 60 percent of the schools include in the required

[16]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

coursework the remaining two topic areas: gender related differences in access to health services due to differences in insurance, economic resources; and ethical issues of women in medical research, including enrollment in clinical trials.

Table 10.10: Number (%) of responding schools of nursing that taught each topic in the "Legal and Ethical Issues" category according to type of course[17] (n=334)

Legal and Ethical Issues	Required Course Content	Elective	Not Offered	Not Reported
Health policy implications on women's health (e.g., family/medical leave, insurance)	237 (71%)	30 (9%)	55 (16%)	20 (6%)
Gender related differences in access to health services due to differences in insurance, economic resources	218 (65%)	28 (8%)	72 (22%)	24 (7%)
Legal issues surrounding rights of women (e.g., abortion, workplace discrimination)	248 (74%)	33 (10%)	41 (12%)	22 (7%)
Ethical issues of women in medical research, including enrollment in clinical trials	229 (68%)	33 (10%)	62 (19%)	21 (6%)
Awareness of research on women/minority health	253 (76%)	34 (10%)	41 (12%)	20 (6%)

Overview of Findings

Table 11 presents the average number and percentage of schools that include the topic areas in the required and elective course content for each of the 10 broad content areas. The average number, percentage, and range of schools that do not offer the topic in the baccalaureate nursing curriculum are also shown. The most frequently required content areas were general topics (95%); sexual and reproductive functioning at various life stages (94%); biologic considerations (91%); etiology, prevalence, course, treatment, and prevention of common health problems of the reproductive tract (89%); and approaches to health behaviors and health promotion in women (86%). The least commonly included broad content areas were etiology, prevalence, course, treatment, and prevention of conditions specifically in women (66%); selected topics (69%); and legal and ethical issues (71%).

[17]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

Table 11: Average number (%) of schools that include the content in the 10 broad topic areas[18] (n=334)

	Average Number & percentage of schools offering the content			
Topics:	**Required Course**	**Elective**	**Not offered[19]**	**Not reported**
General topics (4 items)	317.3 (95%)	14.0 (4%)	5.0 (1%) range: 0-11	3.0 (1%)
Biologic considerations (8 items)	303.8 (91%)	10.8 (3%)	18.6 (6%) range: 3-39	8.1 (2%)
Developmental and psychosocial issues (17 items)	284.1 (85%)	17.2 (5%)	29.1 (9%) range: 4-97	11.8 (4%)
Approaches to health behaviors/health promotion in women (18 items)	295.7 (86%)	16.2 (5%)	18.9 (6%) range: 3-46	10.4 (3%)
Sexual and reproductive functioning at various life stages (7 items)	314.9 (94%)	14.0 (4%)	9.4 (3%) range: 2-31	7.0 (2%)
The etiology, prevalence, course, treatment and prevention of common health problems of the reproductive tract (6 items)	298.8 (89%)	11.8 (4%)	17.7 (5%) range: 5-30	13.8 (4%)
The etiology, prevalence, course, treatment, and prevention of the following conditions specifically in women (19 items)	221.1 (66%)	10.2 (3%)	69:6 (21%) range: 17-118	38.4 (12%)
Health assessment and teaching (17 items)	285.5 (85%)	8.8 (3%)	26.4 (8%) range: 3-77	18.5 (6%)
Selected topics (16 items)	228.9 (69%)	33.5 (10%)	59.1 (18%) range: 9-139	22.1 (7%)
Legal and ethical issues (5 topics)	237.0 (71%)	31.6 (9%)	54.2 (16%) range: 41-72	21.4 (6%)

The findings are further elaborated in Tables 12.1 and 12.2. Table 12.1 illustrates that almost all (98%) entry-level baccalaureate nursing programs do include the impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care utilization; contraception and fertility management; and taking a reproductive history in the required course content of the baccalaureate nursing curriculum. The topics least frequently included in the required course content of entry-level baccalaureate nursing programs are shown in Table 12.2. The topics least frequently included are lesbian health issues (39%); etiology, prevalence, course, treatment, and prevention of temporomandibular joint disease specifically in women (46%); and health issues for women with disabilities (47%).

[18]Required course content and elective course content are not mutually exclusive categories since some schools indicated that content was taught in both required and elective courses.

[19]Range of number of schools that do not offer any of the single topics in this category.

Table 12.1:. List of topics most frequently included in required course content in the 334 responding entry-level baccalaureate nursing programs

Ranking	Topic	Number of schools including topic in required curriculum	Percentage of school including topic in required curriculum
1	Contraception and fertility management	327	98%
1	Impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care utilization	327	98%
3	Taking a reproductive history	326	98%
4	Normal and abnormal female anatomy and physiology	325	97%
5	Normal menstruation	324	97%
6	Other STDs and prevention of risk	323	97%
6	Impact of poverty/socioeconomic status on health status and access to health care	323	97%
8	Female reproductive biology	322	96%
8	HIV/AIDS and prevention of risk	322	96%
10	Intended/unintended pregnancy	321	96%
11	Use of folic acid/folate to decrease incidence of spina bifida	320	96%
11	Breast cancer in women	320	96%

Table 12.2:. List of topics least frequently included in the required course content in the 334 responding entry-level baccalaureate nursing programs

Ranking	Topic	Number of schools including topic in required curriculum	Percentage of school including topic in required curriculum
1	Lesbian health issues	130	39%
2	Temporomandibular joint disease specifically in women	153	46%
3	Health issues for women with disabilities	157	47%
4	Gender specific health care decision making	175	52%
5	Fibromyalgia and chronic fatigue syndrome specifically in women	185	55%
6	Functional bowel disorders specifically in women	191	57%
7	Effects of gender discrimination and sexual harassment	192	57%
8	Intérstitial cystitis specifically in women	193	58%
9	Lipoprotein disorders specifically in women	194	58%
10	Gender specific communication styles	200	60%
11	Workplace harassment	201	60%
11	Migraine/other headache disorders specifically in women	201	60%

Respondents were asked to indicate whether specific topics were included in required or elective courses within the baccalaureate nursing program. Many respondents indicated that content was taught in both required and elective courses. In addition, many respondents did not respond to specific items; therefore, it is not known whether this indicated content was not being taught or that the respondent was unsure whether content

indicated content was not being taught or that the respondent was unsure whether content was being taught. Tables 13.1 and 13.2 show those topics that are definitely not offered by the fewest and the greatest number of baccalaureate nursing programs. The topics that were not included in the fewest number of programs are shown in Table 13.1. No respondent (0%) indicated that the impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care utilization was not included either in the required or elective baccalaureate nursing curriculum. Only two programs (1%) indicated that the impact of poverty/socioeconomic status on health status and access to health care; and contraception and fertility management were not included in the baccalaureate nursing curriculum. The topics that were not included in the baccalaureate nursing curriculum by the greatest number of schools are shown in Table 13.2. Lesbian health issues and health issues for women with disabilities were not included in the curriculum by 42% and 37% of the baccalaureate nursing programs, respectively.

Table 13.1: List of topics not offered by the fewest number of baccalaureate nursing programs (n=334)

Ranking	Topic	Number of schools NOT offering topic in required or elective curriculum	Percentage of schools NOT offering topic in required or elective curriculum
1	Impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care utilization	0	0%
2	Impact of poverty /socioeconomic status on health status and access to health care	2	1%
2	Contraception and fertility management	2	1%
4	Normal and abnormal female anatomy and physiology	3	1%
4	HIV/AIDS and prevention of risk	3	1%
4	Other STDs and prevention of risk	3	1%
4	Taking a reproductive biology	3	1%
8	Female reproductive history	3	1%
8	Domestic violence	4	1%
8	Breast cancer in women	4	1%
8	Normal menstruation	4	1%
8	Intended/unintended pregnancy	4	1%
8	Use of folic acid/folate to decrease incidence of spina bifida	4	1%
8	Common diagnostic testing done during pregnancy	4	1%

Table 13.2:. List of topics not offered by the greatest number of baccalaureate nursing programs in either required or elective course content (n=334)

Ranking	Topic	Number of schools NOT offering topic in required or elective curriculum	Percentage of schools NOT offering topic in required or elective curriculum
1	Lesbian health issues	139	42%
2	Health issues for women with disabilities	124	37%
3	Temporomandibular joint disease specifically in women	118	35%
4	Gender specific health care decision making	100	30%
5	Workplace harassment	97	29%
6	Fibromyalgia and chronic fatigue syndrome of specifically in women	96	29%
7	Interstitial cystitis specifically in women	91	27%
8	Lipoprotein disorders specifically in women	89	27%
8	Functional bowel disorders	89	27%
10	Inflammatory bowel disorders specifically in women	83	25%
10	Respiratory disorders specifically in women	83	25%
10	Migraine/other headache disorders specifically in women	83	25%
13	Gender specific communication styles	82	25%
14	Effects of gender discrimination and sexual harassment	81	24%
15	Patient education/teaching appropriate to the age, gender, and cultural status of women	77	23%
15	Other criminal victimization	77	23%
17	Stroke syndromes specifically in women	76	23%
18	Obesity specifically in women	75	22%
18	Discrimination/oppression	75	22%

Formats Used to Teach Women's Health Content

Respondents were asked to indicate the format(s) or methods primarily used to teach each individual content item. Respondents were allowed to select more than one format. The formats presented were lecture, small group discussion or seminar, clinical practicum, and self-study. The primary formats used by the schools that include each item in the required course content are shown in Table 14.

The primary format used to teach all content areas was lecture. In all but six content areas, small group discussion or seminar format was used second most frequently to teach required course content. In these six content areas, the clinical practicum was used to teach the content more frequently than the small group discussion or seminar format. The six content areas in which the clinical practicum was the second most frequently used teaching format were:

- normal and abnormal female anatomy & physiology;
- female reproductive biology;

- prevalence, pathophysiology, assessment, medical/nursing management and prevention of lung cancer in women;
- prevalence, pathophysiology, assessment, medical/nursing management and prevention of breast cancer in women;
- prevalence, pathophysiology, assessment, medical/nursing management and prevention of colorectal cancer in women; and
- prevalence, pathophysiology, assessment, medical/nursing management and prevention of cancers specific to women (e.g. ovarian, uterine, cervical).

The clinical practicum as a major teaching strategy is particularly important because this represents the students' direct patient care experiences. Patient or hands-on experiences, either real or virtual, help to reinforce or integrate content into the student's knowledge and skill base.

Table 14: Number (%) of schools using various teaching formats to present required course content (n=334)

		Number (%) of schools using teaching format(s) for required content			
Topic	Average No. of schools requiring content No. %	Lecture Format No. %	Small Group Discussion/ Seminar No. %	Clinical Practicum No. %	Self-Study No. %
General Topics	317 (95%)	285 (90%)	201 (63%)	160 (50%)	29 (9%)
Biologic Considerations	304 (91%)	284 (93%)	100 (33%)	89 (29%)	21 (7%)
Developmental and Psychological Issues	284 (85%)	258 (91%)	133 (47%)	86 (30%)	18 (6%)
Approaches to Health Behaviors/Health Promotion	296 (89%)	274 (93%)	124 (42%)	104 (35%)	16 (5%)
Sexual and Reproductive Functioning at Various Life Stages	315 (94%)	296 (94%)	120 (38%)	89 (28%)	18 (6%)
Common Health Problems of the Reproductive Tract	299 (90%)	278 (83%)	96 (32%)	91 (30%)	15 (5%)
The Etiology, Prevalence, Course, Treatment, and Prevention of Other Medical Conditions Specifically in Women	221 (66%)	208 (94%)	63 (29%)	75 (34%)	9 (4%)
Health Assessment and Teaching	286 (85%)	251 (88%)	110 (39%)	109 (38%)	15 (5%)
Selected Topics	229 (69%)	195 (85%)	113 (49%)	72 (31%)	11 (5%)
Legal and Ethical Issues	237 (71%)	207 (87%)	110 (46%)	41 (17%)	12 (5%)

Who Teaches Women's Health Content?

Respondents also were asked to identify the discipline of the individual or individuals primarily responsible for teaching each of the women's health content or topics listed. More than one response was permitted. The choices were:

1. a nurse faculty who has graduate preparation in women's health (e.g. a certified nurse-midwife, women's health nurse practitioner, or a clinical nurse specialist with a specialty in women's health);
2. other nursing school faculty without specialization in women's health;
3. a physician;
4. a psychologist
5. a pharmacist; and
6. other.[20]

The percentages by discipline of those individuals who teach the women's health content in those schools that include the topic in the required coursework of the baccalaureate nursing curriculum are shown in Tables 15.1 through 15.10. The individuals most frequently responsible for teaching a majority of the women's health content are nursing school faculty without a specialization in women's health. A nurse faculty member who has graduate preparation in a women's health specialty was the second most frequently used individual to teach the women's health content in baccalaureate nursing programs. For several specific content areas a nurse faculty member with graduate preparation in a women's health specialty was used most frequently. These content areas were:

- Normal menstruation
- Contraception and fertility management
- Intended and unintended pregnancy
- Preconception and interconceptional health practices (getting to pregnancy in optimal health);
- Use of folic acid/folate to decrease incidence of spina bifida;
- Sequelae of infertility;
- Patient teaching and the application to nursing interventions for endometrial biopsy; and
- Common diagnostic testing done during pregnancy.

[20]When the "other" category was selected, the respondent was not asked to identify the discipline of the individual teaching the content.

Table 15.1: Discipline of faculty members holding primary responsibility for teaching one or more of the "General Topics" when included in required coursework

General Topics

(Average = 317 (95%) schools that include one or more of the four General Topics in required course content.) (See Table 11)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	142.8 (44.9%)
Other nurse faculty without specialization in women's health	194.0 (61.0%)
Physician	0.25 (<1%)
Psychologist	1.0 (<1%)
Pharmacist	0 (0%)
Other	9.5 (2.9%)

Table 15.2: Discipline of faculty members holding primary responsibility for teaching one or more of the "Biologic Considerations" topics when included in required coursework

Biologic Considerations

(Average = 304 (91%) schools that include one or more of the eight Biologic Considerations topics in required course content) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	113.6 (37.4%)
Other nurse faculty without specialization in women's health	205.3 (67.5%)
Physician	4.5 (1.4%)
Psychologist	2.9 (0.9%)
Pharmacist	5.3[21] (1.7%)
Other	47.1 (15.5%)

Table 15.3: Discipline of faculty members holding primary responsibility for teaching one or more of the "Developmental and Psychosocial Issues" topics when included in required coursework

Developmental and Psychosocial Issues

(Average = 284 (85%) schools that include one or more of the 17 Developmental and Psychosocial Issues in required course content.) (See Table 11.)

Discipline	*Average(%) Schools*
Nurse faculty with specialty in women's health	107.5 (32.2%)
Other nurse faculty without specialization in women's health	218.5 (65.4%)
Physician	1.2 (<1%)
Psychologist	4.8 (1.4%)
Pharmacist	0.3 (<1%)
Other	22.3 (6.7%)

[21]One topic, gender differences in pharmacokinetics in drugs, was taught by a pharmacist at 34 schools. No other topic in this area was taught by a pharmacist at more than 3 schools.

Table 15.4: Discipline of faculty members holding primary responsibility for teaching one or more of the "Approaches to health behaviors/health promotion in women" topics when included in required coursework

Approaches to Health Behaviors/Health Promotion in Women

(Average = 296 (89%) schools that include one or more of the 18 Approaches to Health Behaviors/Health Promotion in Women topics in required course content.) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	98.3 (29.4%)
Other nurse faculty without specialization in women's health	248.2 (74.3%)
Physician	0.6 (<1%)
Psychologist	1.3 (<1%)
Pharmacist	0.8 (<1%)
Other	13.6 (4.1%)

Table 15.5: Discipline of faculty members holding primary responsibility for teaching one or more of the "Sexual and reproductive functioning at various life stages" topics when included in the required coursework

Sexual and Reproductive Functioning at Various Life Stages

(Average = 315 (94%) schools that include one or more of the seven Sexual and Reproductive Functioning at Various Life Stages in required course content) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	196.1 (58.7%)
Other nurse faculty without specialization in women's health	156.9 (47.0%)
Physician	0.9 (<1%)
Psychologist	0.6 (<1%)
Pharmacist	0.4 (<1%)
Other	17.1 (5.1%)

Table 15.6: Discipline of faculty members holding primary responsibility for teaching one or more of the "Etiology, prevalence, course, treatment and prevention of common health problems of the reproductive tract" topics when included in required coursework

Etiology, Prevalence, Course, Treatment and Prevention of Common Health Problems of the Reproductive Tract

(Average = 299 (90%) schools that include one or more of the six Etiology, Prevalence, Course, Treatment and Prevention of Common Health Problems of the Reproductive Tract topics in required course content) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	157.8 (47.2%)
Other nurse faculty without specialization in women's health	190.0 (56.9%)
Physician	2.5 (<1%)
Psychologist	0 (0%)
Pharmacist	0.3 (<1%)
Other	6.7 (2%)

Table 15.7: Discipline of faculty members holding primary responsibility for teaching one or more of the "Etiology, prevalence, course, treatment and prevention of conditions specifically in women" topics when included in required coursework

Etiology, Prevalence, Course, Treatment and Prevention of Conditions Specifically in Women

(Average = 221 (66%) schools that include one or more of the 19 Etiology, Prevalence, Course, Treatment and Prevention of Conditions Specifically in Women topics in required course content.) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	46.5 (13.9%)
Other nurse faculty without specialization in women's health	199.1 (59.6%)
Physician	0.7 (<1%)
Psychologist	0 (0%)
Pharmacist	0.6 (<1%)
Other	6.5 (1.9%)

Table 15.8: Discipline of faculty members holding primary responsibility for teaching one or more of the "Health assessment and teaching" topics when included in required coursework

Health Assessment and Teaching

(Average = 286 (85%) schools that include one of more of the 17 Health Assessment and Teaching topics in required course content.) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	123.8 (37.1%)
Other nurse faculty without specialization in women's health	208.5 (62.4%)
Physician	0.9 (<1%)
Psychologist	0.5 (<1%)
Pharmacist	0 (0%)
Other	5.8 (1.7%)

Table 15.9: Discipline of faculty members holding primary responsibility for teaching one or more of the "Selected" topics when included in required coursework

Selected Topics

(Average = 229 (69%) schools that include one or more of the 16 Selected Topics in required course content.) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	81.6 (24.4%)
Other nurse faculty without specialization in women's health	194.6 (58.3%)
Physician	0.2 (<1%)
Psychologist	1.4 (<1%)
Pharmacist	0 (0%)
Other	9.9 (3.0%)

Table 15.10: Discipline of faculty members holding primary responsibility for teaching one or more of the "Legal and ethical issues" topics when included in required coursework

Legal and Ethical Issues

(Average = 237 (71%) schools that include one or more of the five Legal and Ethical Issues topics in required course content.) (See Table 11.)

Discipline	*Average (%) Schools*
Nurse faculty with specialty in women's health	92.6 (27.7%)
Other nurse faculty without specialization in women's health	194.8 (58.3%)
Physician	0 (0%)
Psychologist	0.8 (<1%)
Pharmacist	0 (0%)
Other	10.2 (3.1%)

Baccalaureate nursing programs infrequently used physicians to teach women's health content. Physicians were used to teach only 64 of the specific content areas at any schools of nursing. No content item was taught by a physician at more than two percent of the schools that included the content in the required coursework. The content areas taught by physicians at the two percent of schools that included the content in the required course work are:

- Normal and abnormal female anatomy and physiology;
- Female reproductive biology;
- Genetic influences on health risks of women;
- Sex/gender differences in the pathogenesis of disease and disease mechanisms;
- Sex/gender differences in epidemiology of disease and disease rates; and
- Physiologic effects of reproductive hormones across the lifespan of females.

Thirty-seven of the content areas were taught by a pharmacist at one or more schools. Gender differences in pharmacokinetics of drugs was taught by a pharmacist at 34 (13%) of the schools that include this content in the required coursework. Prescription drug abuse in women was taught by a pharmacist at nine (3%) of the schools that included the content in the required coursework.

Sixty-nine of the content areas were taught by a psychologist at one or more schools. However, no topic or content area was taught by a psychologist at more than five percent of the schools that included the content in the required coursework. The topics that were taught the most frequently by a psychologist, either individually or as a team member, are shown in Table 16.

Table 16: Number (%) of schools in which content is included in the required coursework and a psychologist teaches the women's health content individually or as a team member

Topic:	Number of schools that require the content	Number (%) of schools where psychologist teaches content
Milestones in the developmental process of women	277 (83%)	13 (5%)
Sex/gender differences on development across the lifespan	312 (93%)	9 (3%)
Gender identification and sexual orientation	269 (81%)	9 (3%)
Influence of sex/gender on eating behaviors/disorders	313 (94%)	7 (2%)
Workplace harassment	201 (60%)	6 (3%)
Discrimination/oppression	230 (69%	6 (3%)
Sex/gender differences in the biologic aging process	300 (90%)	6 (2%)
Impact of societal role expectations on women's health	267 (80%)	6 (2%)
Influence of sex/gender on depressive syndromes	308 (92%)	6 (2%)
Influence of sex/gender on addictive behaviors/disorders	304 (91%)	6 (2%)

At least one or more schools indicated that each of the content areas was taught by an individual other than the five disciplines listed. At those schools that included the content in the required coursework, the topics most frequently taught, either individually or as a team member, by a discipline other than those listed are shown in Table 17. When choosing the "Other" category, respondents were not asked to specify who taught the content.

Table 17: Women's health topics most frequently taught by someone in "other" discipline at schools where the content is included in the required coursework

Topic:	Number (%) of schools requiring content	Number (%) of schools where someone in an "other" discipline teaches content
Normal and abnormal female anatomy & physiology	325 (97%)	96 (30%)
Female reproductive biology	322 (96%	91 (28%)
Nutrition	263 (79%)	73 (28%)
Sex/gender differences on development across the lifespan	312 (93%)	51 (16%)
Milestones in the developmental process of women	277 (83%)	44 (16%)
Genetic influences on health risks of women	306 (92%)	42 (14%)
Normal menstruation	324 (97%)	45 (14%)
Physiologic effects of reproductive hormones across the lifespan of females	313 (94%)	42 (13%)

Comparison of Findings with Dental and Medical School Curriculum Surveys

This survey and report on women's health content in entry-level baccalaureate nursing programs was an extension of the efforts by the Federal offices with a focus on women's health to investigate models of education and approaches to teaching women's health in the health professions. A comparison of results from the medical and dental school curriculum findings was presented in *Women's Health in the Dental School Curriculum Report of a Survey & Recommendations* (Silverton, Sinkford, Inglehart, Tedesco, & Valachovic, 1998). In order to allow comparison of results from the nursing, medical, and dental school curriculum surveys, the format of the survey and appropriate content areas were left relatively intact when designing the nursing curriculum survey. A comparison of results among the nursing, dental, and medical school curriculum surveys is made in an attempt to demonstrate the impact health professional education has on the delivery and access to comprehensive and quality health care for women across the life span.

For those specific content items that were similar among the nursing, medical, and dental surveys, comparisons are presented in Table 18. Both the medical and dental school curriculum surveys examined content taught in both United States and Canadian schools. Since responses from the United States and Canadian medical schools were similar, the medical school survey reported responses as an aggregate. However, since the responses from the United States and Canadian dental schools varied considerably, responses were reported separately in the dental school women's health curriculum report. Only responses from the United States' dental schools are used here for purposes of comparison along with the aggregate responses from the United States and Canadian medical schools.

The percentages of nursing, medical, and dental schools *not* offering the content are used for comparison because the method of reporting whether content was included in the curriculum varied among the three surveys. A caveat is made in comparing the results of the three surveys because four years span the time in which the surveys were conducted (medical school survey 1995, dental school survey 1997, and nursing school survey 1999).

Table 18: Comparison of nursing, medical, and dental school curriculum surveys in select content areas

General Topics

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
The impact of gender on health issues across the life stages	3%	9%	39%	Health issues across life stages
The impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care utilization	1%	4%	24%	Race, ethnicity, culture & health beliefs, behaviors and utilization
The impact of poverty/socioeconomic status on health status and access to health care	2%	4%	24%	Poverty, socio-economic status & health, health access

Developmental and Psychosocial Issues

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Pubertal development & changing health issues in young women	7%	0%	22%	Pubertal development & changing health issues in young women
Gender identification and sexual orientation	16%	11%	30%	Gender identification and sexual orientation
Impact of societal role expectations on women's health	13%	44%	32%	Impact of societal role expectations on women's health
Health consequences of traumas experienced by women:	----			***Health consequences of traumas experienced by women:***
Childhood sexual/physical/emotional abuse	3%	11%	18%	Childhood sexual/physical/ emotional abuse
Domestic violence	2%	11%	2%	Domestic violence
Rape Other criminal victimization[22]	5% 30%	0%	28%	Rape/Other criminal victimization

[22]Rape and other criminal victimization were included in the nursing curriculum survey as two separate items.

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Influence of sex/gender on the following conditions:				***Influence of gender on the following conditions:***
Anxiety disorders (panic/phobias)	8%	0%	16%	Anxiety disorders (panic/phobias)
Depressive syndromes	7%	0%	16%	Depressive syndromes
Eating behaviors/disorders	6%	11%	12%	Eating behaviors/disorders
Addictive behaviors/disorders	8%	11%	16%	Addictive behaviors/disorders

Approaches to Health Behaviors/Health Promotion in Women

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Adaptation to stress	8%	22%	26%	Adaptation to stress
Physical fitness & weight management	18%	22%	26%	Physical fitness & weight management
Nutrition	7%	22%	12%	Nutrition
Intentional & unintentional self-inflicted injuries, e.g. suicide	9%	0%	26%	Intentional & unintentional injuries
Tobacco use and cessation	13%	33%	10%	Smoking initiation and cessation
Alcohol use/abuse Other substance use/abuse[23]	7% 9%	33%	6%	Alcohol/other substances use/abuse
Prevalence, pathophysiology, assessment, medical/nursing management and prevention of:[24]		0%	8%	Cancer prevention & screening
Lung cancer in women	10%			
Breast cancer in women	3%			
Colorectal cancer in women	11%			
Cancers specific to women (e.g, ovarian, uterine, cervical)	4%			
Cardiovascular risk prevention and screening	6%	22%	12%	Cardiovascular risk prevention and screening

[23]Alcohol use and other substance use/abuse were included in the nursing curriculum survey as two separate items.

[24]Cancer prevention & screening was divided into four separate items in the nursing curriculum survey.

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Occupational/environmental health hazards	13%	33%	12%	Occupational/environmental health hazards

The Etiology, Prevalence, Course, Treatment, and Prevention of the Following Conditions SPECIFICALLY IN WOMEN:

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Coronary artery disease	24%	11%	10%	Coronary artery disease
Stroke syndromes	34%	22%	8%	Stroke syndromes
Hypertension	30%	11%	10%	Hypertension
Lipoprotein disorders	41%	11%	18%	Lipoprotein disorders
Diabetes	29%	11%	10%	Diabetes
Obesity	32%	22%	14%	Obesity
Fibromyalgia and chronic fatigue syndrome	43%	33% 56%	20% 24%	Fibromyalgia Chronic fatigue syndrome[25]

[25]Fibromyalgia and chronic fatigue syndrome were included in the dental and medical school curriculum surveys as two separate items.

Health Assessment and Teaching

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Taking a reproductive history Taking a sexual history[26]	2% 6%	0%	0%	Taking a sexual and reproductive history
Obtaining history of traumatic events (e.g. domestic violence, rape, incest	10%	0%	17%	Obtaining history of traumatic events (e.g. domestic violence, rape, incest
Understanding gender influences on patient/health provider relationship Understanding cultural background influences on patient/health provider relationship[27]	16% 4%	0%	12%	Understanding how gender/cultural background influence the patient/doctor relationship

Selected Topics:

Nursing Curriculum Survey Content Area	% of Nursing Schools not offering or reporting that content offered (1999)	% of Medical Schools not offering content (1995)	% of Dental Schools not offering content (1997)	Medical/Dental Curriculum Survey Content Area
Women's health issues within and across cultural/ethnic groups	15%	56%	31%	Women's health issues within and across cultural/ethnic groups
Health issues of elderly women	10%	33%	16%	Health issues of elderly women
Lesbian health issues	51%	33%	35%	Lesbian health issues
Health issues for women with disabilities	47%	67%	27%	Health consequences of disabilities in women
Gender specific health care decision making	40%	44%	22%	Gender differences in medical./dental decision making
Gender specific communication styles	34%	56%	24%	Gender specific communication styles
Effects of gender discrimination and sexual harassment	34%	44%	20%	Effects of gender discrimination and sexual harassment

[26]Taking a reproductive and sexual history were included as two separate items in the nursing school curriculum survey.

[27]Understanding gender and cultural background influences on patient/health provider relationship were included as two separate items in the nursing curriculum survey.

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SUMMARY AND CONCLUSIONS

A large majority of entry-level baccalaureate nursing education programs do include a high percentage of women's health topics in the curriculum. One topic, the impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care use, was included in the baccalaureate curriculum, either the required or elective course content, of every school reporting. Fourteen other women's health topics were included in the curriculum of all but one percent or less of the baccalaureate nursing programs reporting information. These findings are particularly significant if health professionals, and more specifically baccalaureate-prepared professional nurses, are to meet the health care needs of this country's current and future female population.

Nursing practice and education traditionally have emphasized a holistic approach to health that encompasses care across the entire life span and is sensitive to such variables as age, sex and gender, culture, race, religion, socioeconomic status, and lifestyle choice. Nurses practice from a holistic base and incorporate bio-psycho-social and spiritual aspects of health (AACN, 1998, p.5). The heavy emphasis on women's health issues in the baccalaureate nursing curriculum stems from this holistic, traditional view of nursing practice.

Domestic violence and rape are included in the required course content of 95 percent and 92 percent, respectively, of the baccalaureate nursing education programs. Childhood sexual, physical, and emotional abuse was included in 94 percent of the programs' required course content. These numbers are extremely important since frequently, nurses are the first contact for many women and children with the health care system. Nurses must be able to recognize victims of such traumas, assess the health consequences of the trauma, and advocate for the victim within the health care system.

Despite the heavy emphasis on women's health issues in the baccalaureate nursing curriculum, there are gaps or areas for improvement. Of the 117 individual women's health topics, two (lesbian health issues and health issues for women with disabilities) were included in less than 50 percent of the schools' required coursework and were not offered at all in 42 percent and 37 percent, respectively, of the baccalaureate nursing curricula. The etiology, prevalence, course, treatment, and prevention of conditions *specifically* in women (e.g. cardiovascular disease, hypertension, diabetes, obesity, osteoporosis, and urinary incontinence) was the broad content area least frequently included in the required course content of baccalaureate nursing programs. Many of these topics may be included in the baccalaureate nursing curriculum but not with the specific focus on women and women's health. As health care research continues to identify differences between the biological and behavioral responses of men and women, a greater emphasis must be placed on the differences that exist in these and other common health conditions. Legal and ethical issues specifically related to women was only included on an average by 71 percent of the baccalaureate nursing programs.

Ninety-eight percent of all baccalaureate nursing programs included the impact of race, ethnicity, and culture on the health status, health beliefs and behaviors, and health care utilization in the required course content. However, only 81 percent of the responding programs included cultural competence in communicating with women. Communication

and health assessment are significant components of the professional nursing role. Therefore, with the growing percentage of women and the increasing diversity of the population, nursing graduates must be able to communicate effectively across settings and populations.

The findings of this survey indicate the presence or absence of women's health content included in the baccalaureate nursing curriculum. No determination can be made regarding the depth or quality of experiences or student outcomes. Schools were asked voluntarily to submit copies of curricula and women's health course descriptions. After reviewing the submitted materials, there was no means within the scope of this study to determine "best practices' or assess the quality of student outcomes. Future research should focus on the types and quality of clinical experiences and student learning outcomes related to women's health

Nursing does make a substantial impact on the health care of women in the United States. A majority of nursing schools, as shown by this survey, recognizes the importance of women's health in the preparation of future professional nurses. The results of this survey reinforce this assumption. Continued vigilance, however, must be maintained to ensure that an even higher percentage of baccalaureate nursing programs prepare graduates who are prepared to address the specific health care needs of women across the lifespan.

A number of schools (22%) reported having dedicated personnel or an office of women's health within the school of nursing. Nineteen percent of the 334 responding schools offered one or more graduate programs with a specialty in women's health. Women's health expertise within schools of nursing represents a significant resource that could be used to advance women's health and women's issues outside of nursing. Schools of nursing with this expertise and resources could and should be encouraged to offer stand-alone courses that would be acceptable and available to undergraduate students in other majors outside of nursing. Increased collaboration among nursing faculty, women's studies faculty, and faculty of the other health professional disciplines in designing and offering women's health courses, would have an impact on the number and breadth of courses offered, research undertaken in women's health, and the integration and inclusion of women's health in all health professional education.

This report on the baccalaureate entry-level nursing curricula reflects only a portion of the impact of nursing on women's health care in this country. Graduate nursing education, particularly that of advanced practice nurses with a specialty in women's health, creates another large cohort of nurses that provide significant women's health care. Nurses at the master's and post-master's level are prepared in nurse practitioner, clinical nurse specialist, and nurse-midwifery programs. Graduates of these programs provide primary care and specialty care to women of all ages and backgrounds. Many of the content areas included in this survey, particularly those focusing on the etiology, prevalence, course, treatment, and prevention of specific conditions in women, are included not only in a greater number of graduate programs but also in much more depth, particularly those with an emphasis on women's health. The full impact nursing has and potentially could have on the health care of women cannot be ascertained without also examining the women's health content included in graduate nursing education programs, particularly adult nurse practitioner, gerontology nurse practitioner, family nurse practitioner, and clinical nurse specialist programs. The knowledge and competencies

particularly adult nurse practitioner, gerontology nurse practitioner, family nurse practitioner, and clinical nurse specialist programs. The knowledge and competencies expected of nurse-midwifery graduates have been clearly delineated by the professional organization, ACNM. An evaluation of graduate nursing curriculum content would also assure a logical progression of skill development beyond the entry-level nursing preparation.

RECOMMENDATIONS

The expanded definition of women's health to include the social, psychological, and spiritual aspects of health has had a significant impact on women's health issues and the emphasis placed on them. The media and policy arenas have created an environment that draws more attention to women's health issues.

Nursing, as a profession dominated by women, traditionally has placed a greater emphasis on women's health than other health professions. However, with the growing diversity and aging of the population and specifically the female population, nursing must examine its current and potential role in addressing the health care needs of this large and growing segment of the population. Based on the information provided by this survey and recommendations put forth previously in the nursing literature, the following recommendations are made regarding advancing women's health in the nursing profession and for strengthening the entry-level baccalaureate nursing education curriculum.

In order to advance women's health in nursing education it is recommended that:

1. Faculty must be vigilant regarding the retention of women's health content currently included in the baccalaureate nursing curriculum.
2. Faculty in schools of nursing should examine the current baccalaureate curriculum to ensure that women's health care issues across the life span are addressed.
3. Women's health content should be approached in the context of environmental, social, economic, political, racial/ethnic, cultural, developmental, spiritual, and biologic factors.
4. Women's health curriculum content should reflect the degree and extent of diversity among women in the population.
5. The baccalaureate nursing curriculum should prepare graduates to work in interdisciplinary teams to provide comprehensive, quality women's health care.
6. Faculty in baccalaureate nursing programs should determine whether the clinical experiences offered are adequate to allow the integration of women's health knowledge and skills into the graduate's comprehension and daily practice.
7. The following specific content areas should be given greater emphasis in the baccalaureate nursing curriculum:
    - gender-specific communication styles and cultural competence in communicating with women;
    - health consequences of traumas experienced by women, especially criminal victimization, discrimination/oppression, and workplace harassment

(childhood sexual/physical/emotional abuse, domestic violence, and rape, were required course content in over 90% of the curricula);
- gender-specific health care decision making;
- physical fitness and nutrition as approaches to health behaviors/health promotion in women;
- sex and gender differences in the etiology, prevalence, course, treatment, and prevention of specific conditions, e.g., cardiovascular disease, respiratory disorders, or gastrointestinal disorders;
- lesbian and gay health issues; and
- health issues for women with disabilities.

8. Leaders in schools of nursing and national nursing organizations should place greater emphasis on faculty development in the area of women's health for faculty who teach in baccalaureate nursing programs and/or are involved in curriculum development at their institutions.
9. Officials of appropriate agencies and professional organizations should initiate a study that examines the quality and characteristics of clinical experiences and student outcomes related to women's health in baccalaureate nursing programs.
10. Appropriate agencies, professional organizations and educational institutions should collaborate to develop a framework for integrating women's health content throughout the baccalaureate nursing curriculum, to include terminal competencies and resources for teaching women's health content.
11. Federal agencies or professional organizations should initiate a study to examine the nature and depth of women's health content in graduate nursing education programs, particularly those that do not have a specific focus on women's health.

More generally, it is recommended that:

12. Faculties at all schools of nursing, medicine, pharmacy, and dentistry should increase collaboration and share resources and expertise in order to advance women's health issues within health professions education.
13. At those institutions that have a National Center of Excellence in Women's Health, faculty in the school of nursing, school of medicine, and other health professions schools should strengthen communication and collaboration to improve the comprehensive nature of and access to appropriate women's health care services and education.
14. Faculty in nursing schools with expertise in women's health should offer an undergraduate course in women's health issues that would be acceptable and available to students with majors other than nursing.
15. The National Council of State Boards of Nursing should review and revise the national registered nurse licensure examination to reflect the importance of knowledge related to women's health care.

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APPENDIX A

Congressional Language Related to Women's Health.

Calendar No. 662

102D CONGRESS *2d Session*	SENATE	REPORT 102–397

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATION BILL, 1993

SEPTEMBER 10 (legislative day, SEPTEMBER 8), 1992.—Ordered to be printed

Mr. HARKIN, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R. 5677]

The Committee on Appropriations, to which was referred the bill (H.R. 5677) making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 1993, and for other purposes, reports the same to the Senate with various amendments and presents herewith information relative to the changes recommended.

Amount of budget authority

Amount of House bill	$240,360,387,000
Amount of Senate bill over House bill	+512,787,000
Total bill as reported to Senate	240,873,174,000
Amount of adjusted appropriations, 1992	219,036,041,000
Budget estimates, 1993	240,406,973,000
The bill as reported to the Senate:	
Over the adjusted appropriations for 1992	+21,837,133,000
Over the budget estimates for 1993	+466,201,000

58–801 cc

Academic and clinical training in women's health

To date, there is no medical specialty which provides comprehensive primary health care to women. The Committee requests that the Office of Research on Women's Health [ORWH] in cooperation with the Health Resources and Services Administration [HRSA] evaluate a random sample of medical school curriculums to determine the extent that women's health issues are addressed. The project must examine at least five medical school curriculums, at both public and private universities. The assessment must include information on the amount and content of academic and clinical training covering women's health care topics. The Committee requests that ORWH and HRSA publish a report presenting their recommendations for a model women's health core curriculum for medical schools.

In addition, the Committee requests that the ORWH establish an advisory board for this project comprised of but not limited to the American Association of Medical Colleges, the American Medical's Women's Association, the National Black Women's Health Project, the American Psychiatric Association, the American Psychological Association, the Consortium of Social Science Associations, the Congressional Caucus for Women's Issues, and the Society for the Advancement of Women's Health Research.

Minority health initiative

The Committee has included $43,000,000 for the minority health initiative. The minority health initiative [MHI] is a major trans-NIH project that supports research and research training activities aimed at improving the health of minority Americans. The MHI will focus on the following goals: closing the health gap that currently exists between minority Americans and the majority populations; and increasing the opportunities for minorities to pursue careers in the biomedical sciences. The NIH will address the minority health life-span issues, including infant mortality, health behaviors of adolescent and young adult minorities, and the health status of older minority Americans. The initiative will also focus on recruitment and retention of minorities in a wide array of research and health care professions.

Office of Minority Programs

The Committee has included $9,500,000 for the Office of Minority Programs. The Office of Minority Programs [OMP] serves as the focal point for coordinating overall NIH policies and programs for improving minority health status, increasing the level and scope of research on health problems that disproportionately affect minorities, and expanding the participation of minorities in biomedical or health service delivery careers. Currently, the OMP's efforts include: supplementary support for ICD's projects that provide research on risk factors prevalent in minority populations; establishment of programs to increase minority participation in clinical research, including clinical trials; and development, recruitment, and retention of minorities in the broad range of careers in biomedical research and health services delivery.

Calendar No. 201

103D CONGRESS *1st Session*	SENATE	REPORT 103–143

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATION BILL, 1994

SEPTEMBER 15 (legislative day, SEPTEMBER 7), 1993.—Ordered to be printed

Mr. HARKIN, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R. 2518]

The Committee on Appropriations, to which was referred the bill (H.R. 2518) making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 1994, and for other purposes, reports the same to the Senate with various amendments and presents herewith information relative to the changes recommended.

Amount of budget authority

Amount of House bill	$259,768,129,000
Amount of Senate bill over House bill	+1,213,014,000
Total bill as reported to Senate	260,981,143,000
Amount of adjusted appropriations, 1993	247,094,751,000
Budget estimates, 1994	265,398,931,000
The bill as reported to the Senate:	
Over the adjusted appropriations for 1993	+13,886,392,000
Under the budget estimates for 1994	−4,417,788,000

72-246 cc

the Office of Rural Health Policy. Therefore, the Committee encourages the Office, consistent with the general criteria it has developed for the evaluation of health services outreach grant applications, to extend delivery of health services to migrant farmworkers through mobile clinic programs.

Building and facilities

The Committee recommends $942,000 for buildings and facilities, the same as the administration request and House allowance and $40,000 below the fiscal year 1993 amount. These funds provide for routine repairs and improvements at the Gillis W. Long Hansen's Disease Center located at Carville, LA.

National practitioner data bank

The Committee recommends $7,500,000 for the national practitioner data bank, which is the same as both the House allowance and the administration request and $1,500,000 over the fiscal year 1993 amount. The $7,500,000 will be provided entirely through the collection of user fees and will cover the full cost of operating the data bank. The data bank was created by Public Law 99–660 to serve as a national source of information on malpractice judgments and settlements and various other disciplinary actions taken against physicians, dentists, and other categories of licensed health professionals.

The Committee is disturbed by the failure of the Department to provide a final report on whether small malpractice payments should be excluded from the reporting requirements of the data bank. A study of this issue was mandated by Public Law 99–660 to be issued by November 14, 1988, and was again requested by the Committee 2 years ago; however, it has still not been received by the Congress. It is the Committee's understanding that this study was completed during the previous administration. Therefore, the Committee directs the Department to release the study within 6 months of the date of enactment of this act.

Program management

The Committee recommends $121,976,000 for program management activities for fiscal year 1994. This is the same as both the administration request and the House allowance and $489,000 above the fiscal year 1993 amount. The Committee concurs with the House regarding program management funds, and expects that HRSA will not tap into funds provided for programs in order to increase administrative accounts.

The Committee recommends that $1,000,000 be used to establish an Office of Women's Health in the Office of the Director of HRSA. The Office of Women's Health will ensure that women's health is given the highest priority through HRSA programs in training, research, treatment, and service.

The Committee continues to be concerned that most health professions schools throughout the country lack a comprehensive women's health training curriculum. The Committee is also concerned that HRSA and the Office of Research on Women's Health [ORWH] at the National Institutes of Health [NIH] have not made adequate progress to address the inadequacy of women's health training in

medical schools. Therefore, the Committee requests that HRSA, in cooperation with ORWH and the PHS Office on Women's Health, conduct a broad-based, national study of the adequacy of academic and clinical training in women's health in the education of health professionals, to be completed by October 1, 1994. The study shall examine the context of disease prevention, health promotion, epidemiology and pathology of disease, and the identification, treatment, and control of disease across a woman's lifespan. The Committee requests that, in conducting the study, HRSA consult with specialty boards, health professions schools, deans, women's health professionals, Members of Congress, consumer groups, and nongovernmental agencies. The Committee requests that HRSA prepare a report, based on the results of this study, which shall address the implications for accreditation and licensure of professions. The report shall also outline the effects of gaps in the knowledge of health professionals on the care that women receive.

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

Appropriations, 1993	$10,900,000
Budget estimate, 1994	9,000,000
House allowance	9,000,000
Committee recommendation	9,000,000

The Committee recommends $9,000,000 for the medical facilities guarantee and loan fund. This is the same as both the administration request and the House amount and $1,900,000 less than the fiscal year 1993 appropriation. These funds are used to comply with the obligation of the Federal Government to pay interest subsidies on federally guaranteed loans throughout the life of the loans. These loans were used for hospital modernization, construction, and conversion.

HEALTH EDUCATION ASSISTANCE LOANS [HEAL]

Appropriations, 1993	$25,148,000
Budget estimate, 1994	26,458,000
House allowance	26,458,000
Committee recommendation	26,458,000

The HEAL Program insures loans to students in the health professions. The Budget Enforcement Act of 1990 changed the accounting of the HEAL Program: one account is now used to pay obligations arising from loans guaranteed prior to 1992, while a second account pays obligations and collects premiums on loans guaranteed in 1992 and later. Administration of the HEAL Program is separate from administration of other HRSA programs.

The Committee recommends guarantee authority of $375,000,000 for new HEAL loans in fiscal year 1994.

The Committee was particularly pleased that, in the fiscal year 1993 allocation of HEAL loans, a bidding process was utilized that employs multiple bids to identify the lender offering the best HEAL loan terms for students. The Committee directs that this again be the process utilized for the fiscal year 1994 allocation of HEAL lending authority.

The Committee provides $64,878,000 to liquidate 1994 obligations from loans guaranteed before 1992, which is the same as both the House allowance and the administration request. In addition,

103D CONGRESS *1st Session* | HOUSE OF REPRESENTATIVES | REPORT 103–156

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATION BILL, 1994

JUNE 24, 1993.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. NATCHER, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R. 2518]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for the Departments of Labor, Health and Human Services (except the Food and Drug Administration, Indian Health Service, and the Office of Consumer Affairs), and Education (except Indian Education), Action, the Corporation for Public Broadcasting, the Federal Mediation and Conciliation Service, the Federal Mine Safety and Health Review Commission, the National Commission on Libraries and Information Science, the National Council on Disability, the National Labor Relations Board, the National Mediation Board, the Occupational Safety and Health Review Commission, the Prospective Payment Assessment Commission, the Physician Payment Review Commission, the Railroad Retirement Board, the United States Soldiers' and Airmen's Home, the United States Institute of Peace and the United States Naval Home for the fiscal year ending September 30, 1994 and for other purposes.

★ 69–704

prehensive federal response to ensure that children are immunized on time, these funds also would provide seed money for emerging vaccine initiatives that have not developed within the normal Federal budget cycle, to increase efforts to ensure vaccine safety, to speed up the development and testing of new vaccines, and to evaluate the success of various State and local vaccine distribution systems.

Office of Research Integrity

The Committee recommends $4,000,000 for the Office of Research Integrity, a reduction of $2,000,000 from the budget request. This Office has been funded in the past by "tapping" the other Public Health Service agencies for the necessary funds The Committee believes that the Department should be able to fund this activity at a somewhat lower level of scarce Federal resources.

The Office of Research Integrity carries out PHS responsibilities to investigate and resolve allegations of scientific misconduct. ORI will continue to develop scientific research policies, integrity procedures, and regulations and to provide an accused scientist an opportunity for an independent adjudicatory hearing or review when an investigation concludes that research misconduct may have occurred. ORI is designed to assure that misconduct allegations are addressed in a manner that assures fairness to all parties

Office on Women's Health

The bill includes $1,000,000 for the Office on Women's Health, the same as the budget request. This Office has been funded in the past by "tapping" the other Public Health Service agencies for the necessary funds.

The Office on Women's Health advises the Assistant Secretary for Health on scientific, legal, ethical, and policy issues relating to women's health. The Office also provides leadership, sets priorities, develops policy and guidance, and reviews and monitors PHS activities in regard to issues of women's health.

The Committee is concerned about the current inadequacy of women's health training in medical school education. Because of a lag in research on women's health, and because almost all medical schools use the 70 kilogram male as their model, medical practitioners have gaps in their knowledge about the special health needs of women. Physicians, therefore, are not adequately trained to address the needs of half of our population, which results in poorer quality care for women and increased costs as some of women's health care needs are misdiagnosed or mistreated.

The Committee intends part of the increase for the Office to be used to examine issues surrounding the appropriate integration of women's health issues into medical school curricula. The Committee directs that the Office work with the various agencies of the Public Health Service, in particular the Health Resources and Services Administration, to study the improvement of competencies in training in the care of women with the goal of educating all physicians in the full range of women's health issues and ending the fragmentation of women's health care. This will ensure the provision of optimal health care to women.

The study should be broad-based, including specialty boards, women's health professionals, specialists in women's health, Members of Congress, medical school representatives, and consumer groups. The Committee would like to receive this study by February 1, 1994.

Office of Emergency Preparedness

The bill includes $1,500,000 for the Office of Emergency Preparedness, a reduction of $1,500,000 from the budget request. This Office has been funded in the past by "tapping" the other Public Health Service agencies for the necessary funds. Because of budgetary constraints on discretionary spending, the Committee was unable to provide the full amount requested.

The Office of Emergency Preparedness (OEP) is responsible for planning, implementing, and coordinating the Departmental response to a disaster. HHS is the primary agency for health and medical services under the Federal Response Plan, and responsibility for the entire Departmental response was delegated to OEP in 1990. Medical, mental health, and human services are provided to victims of catastrophic disasters under the Federal Response Plan.

Health Care Reform Data Analysis

The Committee recommends $3,000,000 to initiate a data improvement and analytical effort in support of health care reform. This is $2,000,000 less than the amount requested because of overall budgetary constraints.

This initiative would fund several interagency efforts aimed at the improvement, expansion and analysis of data in support of health care reform in the areas of employer-provided health insurance, population estimates of health insurance coverage, the efficacy of various cost containment approaches, and related areas. Health care reform efforts will require timely and systematic national information on employer-provided health insurance as well as employer/employee sharing of premium costs.

Public Health Service Management

For Public Health Service Management, the bill includes $19,379,000, a reduction of $2,000,000 from the request and from the 1993 appropriation. This activity provides support for the Assistant Secretary for Health to assure effective guidance, leadership, and direction of the Public Health Service programs. In an effort to reduce administrative and overhead costs, the Committee recommends this reduction. This reduction should be able to be absorbed without seriously affecting any critical activity of the Federal Government.

Within the total, the Committee has provided $200,000 for the Office of Public Health History to conduct an inventory and evaluation of public health materials and programs in use in informal education settings.

The Committee has made several reductions in this account for the staffing of offices, i.e. Emergency Preparedness, Research Integrity. The Committee directs the Department to refrain from "tapping" funds from other PHS agencies to restore these reduc-

APPENDIX B

Writing Group of the 1996 American Academy of Nursing Expert Panel on Women's Health. (1997). Women's Health and Women's Health Care: Recommendations of the 1996 AAN Expert Panel on Women's Health. *Nursing Outlook*, 45 (1), 7 – 15.

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Women's Health and Women's Health Care: Recommendations of the 1996 AAN Expert Panel on Women's Health

Writing Group of the 1996 AAN Expert Panel on Women's Health*

The Expert Panel on Women's Health of the American Academy of Nursing has studied the need for transformative change in women's health services and provides recommendations to facilitate such change in the current system of health care and in nursing education, practice, and policy so that women's health needs may be met more effectively.

Historically in health care and in nursing research, women's health has been viewed as synonymous with reproductive health; however, more recently women's health has been redefined as encompassing the entire life span, and women's health care has been redefined as including health promotion, maintenance, and restoration. The functional aspects of health that are reflected in the capacity of women to perform multiple roles, their ability to adapt to the stresses and strains of daily living, and their overall well-being represent important dimensions of this field and are features that women themselves value highly.[1,2] Understanding women's health requires more than a biomedical view; it requires awareness of the context of women's lives.

The growing recognition that health is intimately related to the context of women's lives warrants examination of economic, social, political, and environmental circumstances for women.[3] Some advocate a shift from viewing women's health as "gynecology" to GYN-ecology, the fit between a woman and her environment.[4] The ecological view of women's health acknowledges that factors directly influencing women's health such as food intake, energy expenditure, reproductive experiences, injury, exposures to toxic and infectious agents, and substance abuse are closely related to the social and physical environments in which women live. Individual characteristics, such as age, genetic makeup, health-related knowledge, skills, and values interact with contextual factors such as access to education, income, work opportunities, family and dependent care responsibilities, or housing availability and quality to influence health status. Community contexts such as the prevalence of domestic and other types of violence and the availability of health and social services, clean water, sanitation services, fuel, employment opportunities, transportation, food supplies, and women's support organizations provide the foundation for the personal services to promote and maintain women's health.[5]

Understanding women's health requires more than a biomedical view; it requires awareness of the context of women's lives.

An ecological view of women's health justifies development of new models of health care for women that include personal health and public health services. Constructing a gender-sensitive health care system necessitates considering women's unique requirements for health and well-being across the life span, supporting environments in which women can thrive rather than merely survive, and expanding research to better understand the factors influencing women's health and how to promote it. The purposes of this article are to describe a comprehensive, life span vision of health care for women and to propose recommendations for nursing education, practice, and health policy. This article also includes an exploration of ways in which those in the profession of nursing can and do contribute to providing women's health care in an era of rapidly changing arrangements for health care.

FUNDAMENTAL FEATURES OF EXCELLENT WOMEN'S HEALTH CARE

Fundamental features of excellent women's health care are that it is:

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- Grounded in an awareness of women's everyday lives
- Reflective of the diversity of women
- Oriented to comprehensive care across the life span
- Incorporated in a range of services
- Delivered by a range of health care providers
- Accessible to all women

Women's health care logically incorporates treatment for diseases that are unique to women, more prevalent among women, or for which there are different risk factors for women than for men.[6] However, women's health care must stem from a definition of women's health that is grounded in an understanding of the everyday lives of women, considering their great diversity.[7] Race, ethnicity, class, age, and sexual orientation distinguish how women experience their health, and their consideration is essential for appropriate delivery of health services. Without attention to the material conditions in which some women live, including their low incomes relative to men's incomes, poor housing conditions, and threats to their personal safety, personal health services can have only limited effects. Thus public health services that address the broader circumstances of women's lives, encompassing sanitation, environmental health, housing, infectious disease surveillance and control, programs for community-based health promotion and disease prevention, nutrition supplementation, and screening services, are essential.

Comprehensive care across life stages

Women's health care across the life span begins with young girls, particularly during the elementary school years (see Table 1). This primarily healthy population benefits most from health promotion and disease prevention programs such as those that emphasize injury prevention and nutrition. Addressing concerns about well-being, sexuality, and abuse and violence and providing immunizations for communicable diseases, such as hepatitis B, are essential elements of these health promotion and disease prevention programs.[8]

Female adolescents face health hazards linked with risky behaviors such as smoking and use of alcohol and other substances. Community-wide prevention and health promotion programs that address injury control, violence, and conflict negotiation are essential because deaths from motor vehicle accidents, violent crimes resulting in homicide, and suicide pose significant threats to this group. Smoking cessation programs and drug and alcohol withdrawal programs must complement prevention efforts. Furthermore, preventing unplanned pregnancies and sexually transmitted diseases (including human immunodeficiency virus) by providing adequate contraceptive counseling and education about safe sexual practices is critical for future fertility and general well-being. Pregnant adolescents need access to a range of services, including prenatal care, preparation and support for teen parenting, abortion services, and counseling about adoption services.[8] Adolescents benefit from nutrition counseling, such as that directed toward preventing and detecting eating disorders, and support for physical fitness, including sports injury prevention and treatment and consideration of body image issues. Prevention, early detection, and treatment of mood disorders, especially depression, are important dimensions of mental health care for this age group.

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Many young adult women face the challenges of childbearing and integrating parenting with the demands of employment and other life roles. Reproductive health services, ranging from preconceptual counseling, contraceptive instruction and prescription, abortion, prenatal care and delivery and postpartum services, and services for parenting are fundamental. In addition, a comprehensive range of services spanning physical examinations for early detection of risk factors and disease, managing stress, counseling about health promotion, and treatment of acute illness episodes, including mood disorder, is needed.[8] Occupational health services that are oriented to employment-related challenges to health should be emphasized for this age group. In addition, services for physical, emotional, and sexual abuse and rape remain essential for adult women through the remainder of life.

During their middle years women bear the health consequences of combining caregiver roles for their children and aging parents or other family members at the same time that they are juggling labor force participation. Rarely does formal health care for the family extend to helping women balance self-care with their responsibilities for care of dependents. Women require close monitoring for early detection of heart disease, breast, cervical, and colon cancer, diabetes, lung disease, and arthritis and other chronic illness.[9] Services for menopausal-related transitions and symptoms, as well as late pregnancy, fertility and infertility issues, and abortion are important for this group. Early detection and treatment of sexually transmitted diseases and AIDS remain important, as do services related to rape and abuse. Mental health services, particularly services for depression and stress-related illnesses, are important. Services for occupational injury remain relevant. Moreover, women need information on age-related changes in risk status, age-appropriate health-promoting activities, meaningful everyday activities that contribute to society, symptoms they can expect, and self-care and symptom management strategies they can initiate for themselves. Retirement counseling and financial planning for retirement and health care in old age are significant concerns for women in mid life.[10]

Older women also need assistance with services such as home care and respite care for family members because of their involvement in caregiving for other family members. Older women live with the cumulative changes of aging, as well as preventable diseases. Heart disease, cancer, diabetes, arthritis, osteoporosis, and lung disease cause chronic health problems and disability for women. Alzheimer's disease and other dementias result in a large number of women needing nursing home placement. In addition to acute care services, including access to pharmaceutical products, older women need restorative care services such as nursing home and home care. Promoting well-being in the face of

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Table 1. Women's Health Care: A Life Span Approach

Population	Health care includes	Population	Health care includes
Young girls	Injury prevention		Managing stress
	Seat belts		Health promotion
	Safe sports participation		Exercise
	Immunizations		Nutrition
	Health lifestyle promotion		Acute illness care
	Physical fitness		Mood disorders
	Nutrition		Depression
	Avoiding smoking		Occupational health services
	Avoiding alcohol		Abuse/violence-related services
	Preventing substance abuse		Physical
	Preventing eating disorders		Emotional
	Well-being		Sexual
	Self-esteem		Rape
	Self-body image	Midlife	Early detection
	Planning for life's work		Heart disease
	Sexuality education		Breast, cervical, and colon cancer
	Personal boundaries		Diabetes
	Choices		Lung disease
	Sex communication		Arthritis
	Safe sex behavior		Other chronic illness
	Preventing sexually transmitted diseases		Support for
	Prevention of abuse/violence		Caregiver roles/dependent care
	Physical		Employment
	Emotional		Parenting
	Sexual		Reproductive help
Adolescents	Avoiding risky behaviors		Late pregnancy
	Smoking		Fertility/infertility
	Alcohol		Abortion
	Substance abuse		Sexually transmitted disease treatment
	Injury control		Menopause
	Violence		Violence and abuse
	Conflict negotiation		Mood disorders, esp. depression
	Suicide prevention		Occupational health services
	Risk reduction	Old age	Caregiver supports
	Smoking cessation		Home care
	Drug and alcohol withdrawal		Respite care
	Prevention		Treatment
	Unplanned pregnancy		Heart disease
	Sexually transmitted diseases		Cancer
	Nutrition counseling		Diabetes
	Fitness promotion		Arthritis
	Sports injury prevention		Osteoporosis
	Early diagnosis and treatment		Lung disease
	Eating disorders		Special services for
	Mood disorders		Alzheimer's disease
Young adults	Reproductive care		Comorbidities/chronic illness
	Preconceptual counseling		Long-term care
	Contraception		Nursing home
	Abortion		Home care
	Prenatal care		Mental health
	Delivery		Depression
	Postpartum		Bereavement
	Parenting support		Substance abuse
	Early detection/screening		Nutrition
	Cervical cancer		Adaptations to aging
	Breast cancer		Housing
	Hypertension		Safety

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disease or institutionalization becomes an increasingly important concern for older women as morbidity has become concentrated during the last years of life and functional changes make it impossible for some women to live alone. Mental health services addressing issues such as depression, bereavement, and substance abuse are important during these years. Because of the prevalence of poverty among older women, nutrition services and supplementation are essential, as are programs for safe and affordable housing.[11]

Range of services

Women can benefit from a health care delivery model that acknowledges their contributions as family health care providers and concerns itself with keeping the caregivers healthy. Moreover, women's concerns need to be taken seriously because of limited knowledge about how women's presentation of health problems differ from that of men.[6] Women need a comprehensive package of services, a real system based on primary care and prevention that includes services ranging from health promotion education and counseling to acute and long-term care, with coordination of specialty services, all in the context of a strong public health system.[12,13]

A range of health services encompassing health promotion, maintenance, and restoration would serve women's health care needs more appropriately than services oriented only to care for acute illness.

A range of health services encompassing health promotion, maintenance, and restoration would serve women's health care needs more appropriately than services oriented only to care for acute illness. At a minimum, such services would include the following:

- Health education and counseling, nutrition, and exercise programs
- Disease screening and prevention services
- Pregnancy/reproductive support services
- Home care services
- Respite care for family members
- Acute care services
- Nursing home and other forms of long-term care
- Hospice care
- Rehabilitation services, including work skills training programs
- Pharmaceutical services

Care management that emphasizes access to appropriate and necessary services and their coordination would have the goal of enhancing women's health, not merely containing cost.

Access to a range of providers

In addition to a comprehensive package of services, women need access to a mix of providers who together deliver health services ranging from health promotion counseling to acute and long-term care. When women's primary care needs are considered from a life span perspective, specialty services to promote reproductive health care, mental health, and other medical and surgical specialties can be integrated within a broader framework of public health that emphasizes needs of diverse populations of women. Provision of these services necessitates a mix of providers, with a balance of primary and specialty care providers. Along with physicians in primary care and specialty practice, nurses, particularly advanced practice nurses such as nurse practitioners, nurse midwives, and clinical nurse specialists, contribute significantly to women's health care. Women's unique health care requirements would be best served by collaboration among a wide range of health care providers, such as nutritionists, social workers, and health educators. As physicians continue to debate whether women would be best served by a new specialty in women's health or re-education of physicians to provide comprehensive services to women,[14,15] those in nursing who are committed to women's health care have examined how to best prepare nurses to provide for women's health care.[16]

Access to health care services

Access to health care is a function of the need for health services, availability of the service, ability to obtain the service, and acceptability of the services.[17] Women use health services more frequently than men and are more likely to have a regular source of health care and health information than are men.[18] Some—but not all—of women's use of health services is attributable to their unique experiences of childbearing. As women age, their use of health services becomes more similar to that of men's.[18] Women receive their health services in a unique pattern across the life span that includes their need for primary health care related to pregnancy. Nurse midwives,

Women's unique health care requirements would be best served by collaboration among a wide range of health care providers, such as nutritionists, social workers, and health educators.

clinical nurse specialists in obstetrics/gynecology, women's health and adult health nurse practitioners, along with family practice physicians and obstetrician/gynecologists, provide primary health care services and reproductive health care to women in a variety of settings. Because of the longevity of women and the high prevalence of poverty among older women, the need for special services for the elderly also distinguishes women's needs from those of men.

The ability to obtain services is a function of one's ability to pay for the service and the availability of time and transportation needed to obtain the services. Estimates indicate that 12 million adult women are uninsured. Women's ability to purchase services differs from that of men's purchasing ability for several reasons. Women's incomes remain lower than men's, effectively limiting their ability to pay for services and for health insurance. In 1991 the median annual income for women employed full-time year round was $20,500. For woman-headed households, the median annual income was $16,600. Women earned about 72 cents for each dollar earned by men.[19] Even when employed, women are more likely than men to live in poverty and receive public assistance rather than have employment-related insurance programs, and they are less likely to be able to purchase private insurance. In addition, employed women may not have a voice in selecting their insurance packages because of their limited

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power in organizations that purchase benefits for workers. These outcomes are a consequence of women's dual responsibilities for family care and employment, which often causes women to be employed part-time and to be overrepresented in the unskilled sector of the labor force. Thus women are unable to qualify for health insurance benefits that are linked to their employment status or require high premiums. As a result, many women must rely on health care insurance that they access through their husbands. Dissolution of their marriages may precipitate loss of health insurance.

Benefits packages that provide the same type of services for women and men often ignore women's unique health care needs. These arrangements leave women without coverage for services that they need during the reproductive years, such as prenatal care, and in old age, such as long-term care. Exclusions of pre-existing conditions unique to women, such as pregnancy, or omissions of cancer screening, pregnancy, delivery, and postpartum care, family planning, or abortion care are common and thus leave women without necessary services. Moreover, in old age, women face the omission of the types of care they may need most: caregiving services, including home care and nursing home care. Instead, most health insurance programs assure access to acute care services. Coverage of acute care but not home care services eliminates services that women are more likely than men to need. Moreover, the shift from acute care services to home care for family members often assumes that a woman will be available to provide the care needed to relatives discharged from hospitals before they are able to resume self-care, which places an increased burden on women as family caregivers. In addition, mental health services are often excluded from health plans.

Even when women can pay for health care, they may not be able to obtain the services they need because of geographic distribution of services, such as family planning, abortion services, pregnancy services, preventive care and screening, and long-term care. In addition to geographic location of services, transportation services, access to services over a wide time span (services are not available during evening and weekend hours in many cases), and on-site services in workplaces, schools, and shelters for homeless women and their children would enhance the ability of women to use the services they need. Acceptability of the service and its appropriateness frequently deter use of services, with some women needing translation services, assistance from an attendant in the case of disability, child care or care for other dependents, and special sensitivity to their needs as women. Gender bias in the delivery of services continues to be an obstacle for many women seeking such care as screening for breast and cervical cancer and treatment for some common diseases, such as heart disease. In some areas, abortion services can be obtained only at great personal risk because of the threat of violent crimes against women seeking an abortion and their care providers. Health promotion services for women are increasingly available in senior centers, but transportation difficulties may make them inaccessible for older women.

POLICY RECOMMENDATIONS FOR TRANSFORMING WOMEN'S HEALTH CARE

On the basis of an ecological view of women's health, women's health care includes a range of personal and public services provided across a woman's lifespan by a range of health care providers in a variety of settings to enhance access to the services. The following recommendations emphasize transformation of the current system of health care, not merely reformation of payment mechanisms, to better serve women.

- Provide health care to all women regardless of ability to pay. Linking health care benefits to employment status will leave some women without benefits when their need for health care may be greatest, for example, during their reproductive years or when they must leave the labor market to care for family members, and may leave many women without a voice in selection of health care benefits packages.
- Provide access to comprehensive health services, including health promotion and maintenance, restoration of health, and prevention of disease. To enhance access to health promotion and prevention services, minimal use of co-payments for health promotion and prevention services is warranted. Services should include the following: prevention, assessment, diagnosis, treatment, referral, and follow-up for acute and chronic physical and mental health problems (including services for drug and alcohol addiction); dental care; nutrition services; health education and counseling; fitness and nutrition programs; care management; home health care, including homemaker services; support for family caregivers, such as respite care and services such as transportation to enhance access; and special services for the chronically ill and disabled, persons with AIDS, the frail elderly, and immigrant populations. Delivery through a system of primary health care providers linking people to necessary specialty services and to public health services is mandatory.
- Provide access to a range of providers for primary care and specialty services, including advanced practice nurses such as nurse practitioners, nurse midwives, and clinical nurse specialists and medical specialists such as gynecologists and obstetricians. Options for choosing to be cared for by a woman are essential.
- Create access to services in a number of sites, for example, schools, workplaces, homes, churches, and public health settings such as community clinics, family planning clinics, birthing centers, nursing homes, intergenerational day care programs for young and old, and senior centers.
- Provide funding for educational programs for advanced practice nurses and for re-training of nurses who have practiced in hospital settings to meet anticipated needs for primary health care providers. Funding to prepare nurses for public health practice through completion of baccalaureate degrees in nursing should be available for nurses with associate degree preparation.
- Expand educational programs to prepare all health care providers to care for women in ways that enhance acceptability of care and reduce gender bias in delivery of services.
- Appoint women to boards that govern health care at all levels and to provider panels in managed care organi-

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zations. The Women's Health Advisory Committee of the San Francisco Department of Public Health[11,20] serves as a model in which women reflecting the diversity of the San Francisco community participated in focus groups reflecting variation in ethnicity, occupation, age, sexual orientation, physical function, insurance coverage, and so forth to forge a model for women's health care. Such participatory research that involves women from the community being served promises to reveal the most appropriate ways of transforming systems to better serve women.

- Expand research and research training that will extend knowledge of women's health. This is necessary to fill gaps in understanding about the cause of and optimum treatments for women's health problems, about health during normal transitions from childhood to adolescence and from middle to old age, and to further understanding of gender differences in a variety of health problems and in responses to therapy. Research training through predoctoral and postdoctoral study should be supported through national research services awards designated for women's health research.
- Enhance the public health infrastructure necessary to support population-based services, such as housing and sanitation, environmental health, infectious disease surveillance, immunization, and screening efforts, particularly in areas in which the majority of the population lives below the poverty level.
- Include in the evaluation of health care quality the availability of gender-specific health services, for example, screening for breast cancer and cervical cancer, adequacy of resources to meet the needs of the population, acceptability to women and accessibility of the services in the geographic area and at times they can use them, and the cost-effectiveness of services.
- Seek and apply for resources for international collaborative projects specific to women's health. The use of research methodologies such as participatory action research that encourage empowerment of women and participation in the research process should be included in the nursing curricula, and appropriate review of research proposals for such work by those with expertise in this scientific approach should be provided.

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NURSING'S CONTRIBUTIONS TO WOMEN'S HEALTH CARE

Members of the nursing profession have a long tradition of providing health services to women. From the inception of modern nursing—marked by Florence Nightingale's treatise in 1859—to the present, nurses have been concerned about promoting the health of women and their families. Nightingale wrote her text "Notes on Nursing" to inform women about how to care for themselves and their families. Since the time of Nightingale, the majority of nurses have been women, and thus they have been well informed about women's health issues as both providers and consumers of health services. In the United States, nurses have been providing primary care and care management services since the Visiting Nurses Association clinic opened in the early 1800s in New York City and the first midwifery service began serving the poor in the Kentucky Hills. Since Lillian Wald made her early home visits to poor women in New York, contemporary nurses have been providing a variety of services to women, including primary health care, acute care, long-term care, home care, and pregnancy and aging-related specialty services.

Nurses with basic and advanced practice preparation can provide significant service to women within a carefully integrated system of health care that is based on a strong foundation of primary care and preventive care services that are carefully coordinated with specialty services, all delivered in a context of strong public health services. Current estimates indicate that advanced practice nurses constitute an important national resource for providing public and personal health services, primary care, and primary health care to women in an era of health care reform.

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Primary care and primary health care: the viewpoint of nursing

Primary care has been defined as the provision of integrated, accessible services by clinicians who are accountable for addressing the majority of personal health care needs, developing partnerships with patients, and practicing in the context of family and community.[21,22] Nursing's perspective of primary care is defined more broadly and envisions primary care as prevention-oriented general wellness and illness care for individuals and families. Primary care reflects the principles of primary health care as defined by the World Health Organization (1978): collaboration among individuals, community, and professionals to determine which health problems to address and how to address them; every individual's right to essential health care and responsibility for self-care as well as promotion of the community's health; and emphasis on health promotion and prevention of problems rather than cure of illness. Primary health care is oriented to a community and the culture of the community. Primary care, a subset of primary health care, is personal health care for individuals and families.[22]

Approximately 400,000 of the 2.2 million registered nurses in the United States are delivering primary care. About 300,000 of these registered nurses deliver many aspects of primary care in community and ambulatory care settings, including physician's offices and clinics (125,000), community and public health settings (111,000), schools (48,000), and occupational health sites (22,000). An estimated 100,000 are advanced practice nurses.

Nurse practitioners, certified nurse midwives, and clinical nurse specialists, such as certified psychiatric-mental health nurses, are educated at the master's degree level in nursing and are prepared to deliver primary care services. (One exception is the preparation of family planning nurse practitioners, who are currently prepared in a narrowly focused program designed to meet an important public health demand.) Advanced practice nurses currently provide primary health care to women in a variety of settings, including clinics, health maintenance organizations, and work sites. They constitute an important national health care resource for the provision of primary care services that complements the services provided by primary care physicians, including family practice and internal medicine physicians, who are currently in short supply. An estimated 50,000 nurse practitioners, 58,000 clinical nurse specialists, and 6000 certified nurse midwives currently contribute significantly to women's health care (ANA Practice Council, personal communication, 1994). The scope of practice for advanced practice nurses includes several options for caring for women. In addition, an estimated 700,000 baccalaureate-prepared registered nurses have generalist preparation that includes preparation for public health and community-based care.

Nurse practitioners deliver a wide range of primary care services to women, and some practitioners have special expertise in women's reproductive health care. Adult health care nurse practitioners deliver services to both women and men, spanning their primary care needs. An estimated 5380 adult health care nurse practitioners have been certified by the American Nurses Association (ANA). Many practice in clinics that serve low-income women and their families. Family nurse practitioners are prepared to provide primary care services to children and adults. An estimated 6770 family nurse practitioners have been certified by the ANA and many practice in settings serving low-income families.[23] Nurse midwives provide comprehensive prenatal, intrapartum, and postpartum care to women during the prenatal period. An estimated 5600 nurse midwives have been certified by the American College of Nurse Midwives, and estimates are that approximately 4300 are practicing (American College of Nurse Midwives, personal communication, 1994). An estimated 5674 women's health care nurse practitioners have been certified by the National Certification Corporation, and the majority practice in organizations serving poor women (ANA Practice Council, personal communication, 1994). Psychosocial nurse clinical specialists provide comprehensive mental health services, including prescription of psychotropic medications and therapy for children and adults. An estimated 5071 psychosocial nurse specialists have been certified by the ANA. Given the prevalence of mental health problems experienced by women and women's willingness to seek health care for their problems, most psychosocial nurse specialists serve high proportions of women in their practices. Geriatric nurse practitioners (GNP) provide primary health care to the elderly. An estimated 1572 GNPs have been certified by the ANA (unpublished data, American Nurses Credentialing Center, 1994). Given the high proportion of women among the elderly, GNPs can make a significant contribution to women's health care.

Table 2. Number of Nurses Certified by Examination by the National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties

Certification examination	Number of nurses certified
Women's health care nurse practitioner	7419
Inpatient obstetrical nursing	23,467
Reproductive endocrinology and infertility nursing	536
Ambulatory women's health care	718
High-risk obstetrical nursing	322
Maternal newborn nursing	725

Data from NCC, 1996

Given the high proportion of women among the elderly, geriatric nurse practitioners can make a significant contribution to women's health care.

Registered nurses also contribute to primary health care by practicing collaboratively with nurse practitioners, physicians, and physician assistants in delivering primary health care. In addition, registered nurses prepared with a bachelor's degree in nursing provide public health nursing services that include personal health services and services for the community as a whole. Registered nurses certified by the NCC collaborate in the provision of prenatal care, care during labor and birth, and postpartum services to women (NCC, personal communication). Table 2 indicates the number of nurses certified in these areas.

Acute, long-term and home care services

In acute care settings, clinical nurse specialists with certification in areas such as obstetrics, gynecology, and oncology nursing care for women during hospitalization and are frequent collaborators in the care of women as they make the transition from hospital to home- and clinic-based care. Nurses caring for women in acute care settings have also been certified in obstetrical and gynecological nursing by the NCC, as indicated in Table 2.

In long-term care settings, nurses care for populations of older people, the majority of whom are women. Geriatric nurse practitioners increasingly provide the primary care to the elderly in nursing homes and other residential facilities. Most of the health care provided to older people in long-term care settings is provided by nurses and nursing assistants. Nursing services constitute the bulk of home care services, particularly for older women and often for their chronically ill or disabled family members. Registered nurses supervise and direct the services provided by nursing assistants and home health aides. In addition, they coordinate respite care services in settings such as adult day care centers and in the home.

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Public health

The goal of public health services is to preserve and improve the health of the population. By developing and implementing population-based services for health promotion and screening of high-risk populations and by providing preventive services, public health nurses can affect the lives of all women in the population. In addition, public health nurses provide personal health services to special populations and often coordinate care for women during their childbearing years and old age. Public health nurses often provide services (such as immunization programs, screening, and community education related to lifestyle modification, behavioral change, and modification of environmental conditions) that support or supplement the delivery of personal health services. An estimated 2492 nurses have been certified by the ANA as community health nurses, and 238 have been certified as clinical specialists in community health nursing (unpublished data, American Nurses Credentialing Center, 1994). Increasingly nurses are involved in the development and implementation of programs that take into account the perspectives and contributions of individuals and their communities, such as programs for people of color, gays/lesbians, and older people. The empowerment of women through these efforts contributes significantly to enhancing women's health.

RECOMMENDATIONS FOR NURSING EDUCATION, PRACTICE AND POLICY

The number of primary care providers needed for the next two decades exceeds the supply. Estimates indicate that there will be a shortage of 35,000 primary care physicians by the year 2000 and a shortage of nearly 80,000 of these physicians by the year 2020. Advanced practice nurses, particularly nurse practitioners, could increase the number of primary care providers by 20%.[24]

Nursing education and nursing practice opportunities must be expanded if advanced practice nurses and other registered nurses are to contribute to the advancement of women's health care in the coming decades. The following recommendations pertain:

- Strengthen the emphasis on women's health and women's health care throughout undergraduate programs.
- Emphasize gender differences in health, including diagnosis and treatment, and strengthen public health nursing programs that are gender specific and reflect the diversity within populations of women.
- Increase the resources devoted to preparation of nurses for advanced practice, with particular emphasis on primary care for women as a component of primary health care. All programs, including those that prepare clinical nurse specialists with an acute care emphasis, should prepare nurses for delivery of services to women. Programs designed to prepare nurses for advanced practice in women's health should emphasize comprehensive services for women across their life span, including reproductive health care. Curricular models such as those from the University of California, San Francisco, the University of Illinois, the University of Texas, the University of Washington, and other universities that offer comprehensive programs in women's health should be available to aid curricular design and revisions in other existing programs.[16,25,27]
- Identify practice models for better delivery of health services to underserved populations of women, provide health care in a variety of sites (e.g., schools, workplaces, churches, senior centers, and housing sites) and utilize those sites for the education of students.
- Amend practice acts that govern the practice of nursing to reflect the services that advanced practice nurses are certified and prepared to provide.
- Change through legislation the reimbursement schemes that restrict the practice of advanced practice nurses, particularly nurse practitioners and clinical nurse specialists.
- Study the effectiveness of alternative models of service delivery for women. Inclusion of women's communities as critical participants in forging recommendations for new models of health care and the use of participatory action research techniques to study new models should be encouraged.[10]
- Seek representation by nurses, including advanced practice nurses, on all providers boards, such as hospital, health department, and HMO provider panels.

Nursing education and nursing practice opportunities must be expanded if advanced practice nurses and other registered nurses are to contribute to the advancement of women's health care in the coming decades.

In sum, the provision and study of health care for women is of the highest concern for nurses, both from a professional and a personal standpoint. The foci for nursing in the field of women's health care include the contexts of women's lives as they affect the health status of individual women and populations of women; the diversity of health care needs as they are related to age, life phase, ethnicity, and race; and the current gender bias of our health care delivery and payment schemes. It is imperative that we in nursing practice, education, and research are knowledgeable about, able to advocate for, and participate in any changes being forged for health care policy and services. Guiding the evolution of our educational programs and orienting our research endeavors strongly in the direction of women's health will enable nursing practice and knowledge to have significant influence on health care for women. ■

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APPENDIX C

Excerpts from the American Association of Colleges of Nursing's *The Essentials of Baccalaureate Education for Professional Nursing Practice.*

American Association of Colleges of Nursing. (1998) *The Essentials of Baccalaureate Education for Professional Nursing Practice.* Washington, DC: Author. Pages 9-17.

The Essentials of Baccalaureate Education for Professional Nursing Practice

American Association of Colleges of Nursing. (1998) *The Essentials of Baccalaureate Education for Professional Nursing Practice*. Washington, DC: Author. Pages 9-17.

Core Competencies

Critical Thinking

Critical thinking underlies independent and interdependent decision making. Critical thinking includes questioning, analysis, synthesis, interpretation, inference, inductive and deductive reasoning, intuition, application, and creativity.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- use nursing and other appropriate theories and models, and an appropriate ethical framework;
- apply research-based knowledge from nursing and the sciences as the basis for practice;
- use clinical judgement and decision-making skills;
- engage in self reflection and collegial dialogue about professional practice;
- evaluate nursing care outcomes through the acquisition of data and the questioning of inconsistencies, allowing for the revision of actions and goals;
- engage in creative problem solving.

Communication

Communication is a complex, ongoing, interactive process and forms the basis for building interpersonal relationships. Communication includes listening, as well as oral, nonverbal, and written communication skills.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- demonstrate communication skills during assessment, intervention, evaluation, and teaching;
- express oneself effectively using a variety of media in a variety of contexts;
- assist patients to access and interpret the meaning and validity of health information;
- establish and maintain effective working relationships within an interdisciplinary team;
- adapt communication methods to patients with special needs, e.g., sensory or psychological disabilities;
- produce clear, accurate, and relevant writing;
- use therapeutic communication within the nurse-patient relationship;
- appropriately, accurately, and effectively communicate with diverse groups and disciplines using a variety of strategies; [28]
- access and utilize data and information from a wide range of resources;
- provide relevant and sensitive health education information and counseling to patients; *
- thoroughly and accurately document interventions and nursing outcomes; and
- elicit and clarify patient preferences and values.

Assessment

Assessment is gathering information about the health status of the patient, analyzing and synthesizing those data, making judgements about nursing interventions based on the findings, and evaluating patient care outcomes. Assessment also includes understanding the family, community, or population and utilizing data from organizations and systems in planning and delivering care.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- perform a risk assessment of the individual including lifestyle, family and genetic history, and other risk factors;*

*Competency of particular relevance to women's health

- perform a holistic assessment of the individual across the lifespan, including a health history which includes spiritual, social, cultural, and psychological assessment, as well as a comprehensive physical exam;*
- assess physical, cognitive, and social functional ability of the individual in all developmental stages, with particular attention to changes due to aging;*
- evaluate an individual's capacity to assume responsibility for self care;
- perform a health assessment of the family;
- perform a community health risk assessment for diverse populations;
- perform an assessment of the environment in which health care is being provided; and
- use assessment findings to diagnose, plan, deliver, and evaluate quality care.

Technical Skills

Acquisition and use of technical skills are required for the delivery of nursing care. While the baccalaureate graduate must be adept at performing skills, major roles will also include teaching, delegating, and supervising the performance of skilled tasks by others. Consequently, graduates must approach their understanding and use of skills in a sophisticated theoretical and analytic manner. The acquisition of new skills is an ongoing component of the nursing career. Skill development should focus on the mastery of core scientific principles that underlie all skills, thus preparing the graduate to incorporate current and future technical skills into other nursing responsibilities, and apply skills in diverse contexts of health care delivery.

The teaching, learning, and assessment of any given skill should serve as an exemplar that focuses as much on helping the student learn the process for lifelong self-mastery of needed skills, as on the learning of the specific skill itself. The emphasis must be on helping students identify those skills essential for baccalaureate nursing practice and understanding the scientific principles that underlie the application of these skills.

The following skills are currently deemed essential for every graduate of a baccalaureate program. The graduate should be able to perform, teach, delegate, and supervise these skills with safety and competence. As nursing practice changes to meet the needs of contemporary health care delivery, required skills and expectations related to the graduate's competence must be reviewed and revised.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- monitor and assess vital signs, including pulse and respiratory rates, temperature, pulse oximetry, blood pressure, and three-lead electrocardiogram;
- provide appropriate individual hygiene maintenance;
- apply infection control measures;
- assess and manage wounds, including irrigation, application of dressings, and suture/staple removal;
- provide and teach ostomy care;
- apply heating and cooling devices;
- apply and teach proper positioning and mobility techniques, including range of motion exercises, transferring, ambulating, and use of assistive devices;
- provide nursing care using proper safety techniques, including the use of call systems, identification procedures, appropriate use of restraints, and basic fire, radiation, and hazardous materials protection;
- administer CPR;
- perform specimen collection techniques;
- perform accurate intake and output calculations and recording;
- administer medications by all routes;
- initiate, assess, and regulate intravenous therapies;
- demonstrate the proper use and care for various therapeutic tubes and drains;
- provide comfort and pain reduction measures including positioning and therapeutic touch;
- provide care of the respiratory system, including chest physiotherapy, oxygen therapy, resuscitation, spirometry, and suctioning;
- provide teaching, and emotional and physical support in preparation for therapeutic procedures; and
- provide pre-operative and post-operative teaching and care.

Core Knowledge

Health Promotion, Risk Reduction, and Disease Prevention

Health promotion requires knowledge about health risks and methods to prevent or reduce these risks. Knowledge of the expected growth and development of individuals across the lifespan is essential. Disease prevention knowledge includes methods of keeping an illness or injury from occurring, diagnosing and treating a disease early in it course, and preventing further deterioration of an individual's functioning due to disease. Health promotion and disease prevention enable individuals to achieve and maintain an optimal level of wellness across the lifespan, and decrease disparities in health that exist across populations.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- assess protective and predictive factors that influence the health of patients;
- assess genetic factors and risks that influence the health of individuals;
- foster strategies for health promotion, risk reduction, and disease prevention across the life span;*
- recognize the need for and implement risk reduction strategies to address social and public health issues, including societal and domestic violence, family abuse, sexual abuse, and substance abuse;*
- use information technologies to communicate health promotion/disease prevention information to the patient in a variety of settings;
- develop an awareness of complementary modalities and their usefulness in promoting health;
- assist patients to access and interpret health information to identify healthy lifestyle behaviors;
- initiate community partnerships to establish health promotion goals and implement strategies to meet those goals;
- evaluate the efficacy of health promotion and education modalities for use in a variety of settings and with diverse populations; and
- demonstrate sensitivity to personal and cultural definitions of health

Illness and Disease Management

Illness and disease management requires knowledge about pharmacology, pathophysiology of disease, and assessment and management of symptoms across the lifespan. Also, knowledge about the social, physical, psychological, and spiritual responses of the individual and family/caregiver to disease and illness is required. The goal is to maximize the quality of life and maintain optimal level of functioning throughout the course of illness, including end of life.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- assess and manage physical and psychological symptoms related to disease and treatment;
- assess and manage pain;
- administer pharmacological and non-pharmacological therapies;
- demonstrate sensitivity to personal and cultural influences on the individual's reactions to the illness experience and end of life;*
- maintain, restore, and optimize an individual's level of functioning;
- anticipate and manage complications of disease progression;
- assist patients to achieve a peaceful end of life; and
- anticipate, plan for, and manage physical, psychological, social, and spiritual needs of the patient and family/caregiver.*

Information and Health Care Technologies

Information technology includes traditional and developing methods of discovering, retrieving, and using information in nursing practice. Health care technology includes methods and equipment designed to provide assessment data and support anatomic and physiological function. Baccalaureate graduates intercede between the patient and technology; therefore, the ability to assess the need for, as well as the efficacy and use of technology is critical.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- use information and communication technologies to document and evaluate patient care, advance patient education, and enhance the accessibility of care;
- use appropriate technologies in the process of assessing and monitoring patients;
- work in an interdisciplinary team to make ethical decisions regarding the application of technologies and the acquisition of data;
- adapt the use of technologies to meet patient needs;
- teach patients about health care technologies;
- protect the safety and privacy of patients in relation to the use of health care and information technologies; and
- use information technologies to enhance one's own knowledge base.

Ethics

Ethics includes values, codes, and principles that govern decisions in nursing practice, conduct, and relationships. Skill and knowledge in resolving conflicts related to role obligations and personal beliefs are necessary. Baccalaureate graduates must be able to identify potential and actual ethical issues arising from practice and assist patients in addressing such issues; therefore, knowledge of ethics and ethical decision making is critical.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- clarify personal and professional values and recognize their impact on decision making and professional behavior;
- apply a professional nursing code of ethics and professional guidelines to clinical practice;
- apply an ethical decision-making framework to clinical situations that incorporates moral concepts, professional ethics, and law and respects diverse values and beliefs;
- apply legal and ethical guidelines to advocate for patient well-being and preferences;
- apply communication, negotiation, and mediation skills to the ethical decision-making process;
- demonstrate accountability for one's own practice;
- take action to prevent or limit unsafe or unethical health and nursing care practices by others; and
- enable individuals and families to make quality-of-life and end-of-life decisions and achieve a peaceful death.

Human Diversity

Human diversity includes understanding the ways cultural, racial, socioeconomic, religious, and lifestyle variations are expressed. Baccalaureate graduates must be able to apply knowledge of the effects these variations have on health status and response to health care.

Skills in a second language are highly desirable for graduates of baccalaureate nursing programs. Opportunities should be provided for students to learn languages and to integrate language skills into clinical practice.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- understand how human behavior is affected by culture, race, religion, gender, lifestyle and age;*
- provide holistic care that addresses the needs of diverse populations across the life span;*
- work collaboratively with health care providers from diverse backgrounds;
- understand the effects of health and social policies on persons from diverse backgrounds;* and
- advocate for health care that is sensitive to the needs of patients, with particular emphasis on the needs of vulnerable populations.

Global Health Care

Global health care knowledge includes an understanding of the implications of living with transportation and information technology that link all parts of the world. Information about the effects of the global community on such areas as disease transmission, health policy, and health care economics is required.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- understand the global environment in which health care is provided; and
- modify patient care in response to global environmental factors (e.g., international law and international public health) or seek appropriate consultation in order to do so.

Health Care Systems and Policy

Knowledge of health care systems includes an understanding of the organization and environment in which nursing and health care is provided. Health care policy shapes health care systems and helps determine accessibility, accountability, and affordability.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:
- understand how health care delivery systems are organized and financed, and the effect on patient care;
- identify the economic, legal, and political factors that influence health care delivery;
- participate in efforts to influence health care policy on behalf of patients or the profession;
- incorporate knowledge of cost factors in delivering care; and
- understand the effect of legal and regulatory processes on nursing practice and health care delivery.

Role Development

Provider of Care

The baccalaureate graduate uses theory and research-based knowledge in the direct and indirect delivery of care to patients, and in the formation of partnerships with patients and the interdisciplinary health care team.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:
- integrate theory and research-based knowledge from the arts, humanities, and sciences to develop a foundation for practice;
- apply appropriate knowledge of major health problems and cultural diversity in performing nursing interventions;
- demonstrate knowledge of the importance and meaning of health and illness for the patient in providing nursing care;
- apply health care technologies to maximize optimal outcomes for patients;
- participate in research that focuses on the efficacy and effectiveness of nursing interventions;
- delegate and supervise the performance of nursing interventions;
- incorporate principles of quality management into the plan of care;
- utilize outcome measures to evaluate effectiveness of care;
- perform direct and indirect therapeutic interventions;
- develop a comprehensive plan of care in collaboration with the patient;
- serve as the patient's advocate;
- integrate care with other members of the interdisciplinary health care team; and
- evaluate and assess the usefulness in integrating traditional and complementary health care practices.

Designer/Manager/Coordinator of Care

The baccalaureate graduate is a health care designer, coordinator, and manager. Utilizing information from numerous sources, the professional nurse guides the patient through the health care system. Skills essential to this role development are communication, collaboration, negotiation, delegation, coordination, and evaluation of interdisciplinary work, and the application of outcome-based practice models.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:
- assume a leadership role within one's scope of practice;
- coordinate and manage care to meet the special needs of vulnerable populations, including the frail elderly, in order to maximize independence and quality of life;*
- coordinate the health care of individuals across the lifespan utilizing principles and knowledge of interdisciplinary models of care delivery and case management;*

- delegate and supervise the nursing care given by others while retaining the accountability for the quality of care given to the patient;
- organize, manage, and evaluate the development of strategies to promote healthy communities;
- organize, manage, and evaluate the functioning of a team or unit;
- use appropriate evaluation methods to analyze the quality of nursing care; and
- utilize cost-benefit analysis and variance data in providing and evaluating care.

Member of a Profession

The baccalaureate graduate must have an understanding of the nurse as a professional, as well as knowledge and experiences that encourage the nurse to embrace lifelong learning, incorporate professionalism into practice, and identify with the values of the profession.

Course work or clinical experiences should provide the graduate with the knowledge and skills to:

- understand the history and philosophy of the nursing profession;
- incorporate professional nursing standards and accountability into practice;
- advocate for professional standards of practice using organizational and political processes;
- understand limits to one's scope of practice and adhere to licensure law and regulations;
- articulate to the public the values of the profession as they relate to patient welfare;
- negotiate and advocate for the role of the professional nurse as a member of the interdisciplinary health care team;
- develop personal goals for professional development; and
- participate in professional organizations, working to support agendas that enhance both high quality, cost-effective health care, and the advancement of the profession.

APPENDIX D

Association of Women's Health, Obstetric and Neonatal Nurses. (1996). *The Women's Health Nurse Practitioner: Guidelines for Practice and Education*. Washington, DC: Authored with the National Association of Nurse Practitioners in Reproductive Health.

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These guidelines are included here as an example of competencies developed for specialized graduate nursing education in women's health.

The Women's Health Nurse Practitioner:

Guidelines for Practice and Education

AWHONN
Association of Women's Health, Obstetric and Neonatal Nurses

NANPRH

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The Women's Health Nurse Practitioner:

Guidelines for Practice and Education

These guidelines have been prepared by a joint AWHONN and NANPRH task force. Guidelines are reviewed periodically. These guidelines are not intended to be exhaustive; other sources of information and guidance are available and should be consulted. These guidelines are not designed to define standards of practice for clinical or legal purposes. Variation and innovations that demonstrably improve the quality of patient care are to be encouraged.

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THE WOMEN'S HEALTH NURSE PRACTITIONER: GUIDELINES FOR PRACTICE AND EDUCATION

The Women's Health Nurse Practitioner: Guidelines For Practice and Education has been reviewed by members of the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and the National Association of Nurse Practitioners in Reproductive Health (NANPRH), as well as a multidisciplinary panel of experts who were designated as consultants. They were selected because of their expertise in the area of women's health, nursing education, or clinical practice. In addition, these guidelines have been reviewed and approved by the AWHONN Committee on Practice and the NANPRH Council on Accreditation. We are indebted to all who shared their time and expertise in developing this document.

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INTRODUCTION

This document has been prepared jointly by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and the National Association of Nurse Practitioners in Reproductive Health (NANPRH). The authors of these guidelines recognize the need for consultation among organizations that represent specialty nurses and the need for the women's health nurse practitioner to have clear, unified guidelines for practice and education.

This document defines the women's health nurse practitioner role on the health care team, identifies practice guidelines and competencies of practice, and serves as a guide for nurse practitioner education programs in women's health.

PRACTICE GUIDELINES

ROLE DEFINITION AND CERTIFICATION

The women's health nurse practitioner is a specialist in the field of women's health. Practitioners are licensed as registered nurses in the states in which they practice. Practitioners function as advanced practice registered nurses and thus are subject to the rules and regulations of the practice act of the states where they are licensed.

The women's health nurse practitioner is prepared through a formal course of academic and clinical study to deliver health care to women throughout the life span, with an emphasis on reproductive-gynecologic health. The practitioner provides comprehensive health care in a variety of settings. Comprehensive health care includes wellness promotion and the provision of primary care.

The role of the women's health nurse practitioner is dynamic as it adapts to societal needs and changes in the theory and technology of women's health care and the reimbursement for that care. The nurse practitioner collaborates with a multidisciplinary health care team to provide comprehensive care that is coordinated around the client's needs. Nurse practitioners are responsible and accountable for the outcomes of their practice.

The women's health nurse practitioner is an advanced practice nurse and, therefore, assumes the professional responsibility to attain and maintain national certification. Certification provides evidence to the client and the community that the individual has achieved knowledge beyond basic nursing.

GUIDELINE I. CLIENT CARE

The women's health nurse practitioner provides primary health care to women across the lifespan, with an emphasis on reproductive-gynecologic health. The practitioner uses the processes of assessment, diagnosis, management, and evaluation to provide care that integrates the psychosocial and physical needs of women.

Competencies:

- Demonstrates critical thinking and diagnostic skills in clinical decision making
- Obtains a comprehensive health history and psychosocial data base
- Assesses for evidence of domestic violence or sexual abuse
- Performs a comprehensive physical assessment
- Recognizes emergency situations and initiates emergency care
- Orders, performs, and interprets screening and diagnostic procedures and tests
- Develops and analyzes differential diagnoses that are based on clinical and laboratory data
- Recommends diagnostic and therapeutic interventions with attention to safety, efficacy, and cost effectiveness
- Prescribes medications as regulated by individual state nurse practice acts and educates the client about the drug regimens, interactions, and side effects
- Incorporates non-pharmacologic therapies into practice
- Evaluates results of interventions using accepted outcome criteria, revises the plan accordingly, and consults and/or refers when needed
- Provides health promotion and disease prevention while cognizant of age, developmental status, disability, culture, ethnicity, and sexual orientation
- Provides clinical management, including therapeutic procedures for women with selected gynecologic problems
- Manages the treatment of sexually transmitted infections for clients and their partners
- Provides care to men with selected reproductive health needs or problems
- Provides comprehensive family planning care
- Provides prenatal and postnatal care, including attention to maternal/fetal health and parent/infant relationships
- Identifies high risk pregnancies and collaborates with physicians and other health care providers for management or referral
- Provides management and referral for nonreproductive health problems
- Provides case management
- Collaborates with other health care providers to achieve optimal outcomes

- Applies and/or participates in research to promote evidence-based practice and to facilitate effective care
- Records the client's data accurately

GUIDELINE II. NURSE-CLIENT RELATIONSHIP

The women's health nurse practitioner establishes a therapeutic relationship with the client.

Competencies:

- Promotes a physically safe and confidential environment for care
- Establishes a partnership with the client that facilitates decision making and self-care consistent with the client's health belief system
- Acknowledges personal values and cultural differences; understands their impact on the provider/client relationship
- Recognizes and communicates acceptance of the client's feelings and concerns
- Provides care that is nonjudgmental and sensitive to client needs
- Functions as the client's advocate
- Offers comfort and emotional support to clients and their families
- Delivers health care in a caring manner
- Promotes client autonomy, dignity, and self-determination

GUIDELINE III. HEALTH EDUCATION AND COUNSELING

The women's health nurse practitioner plans, develops, coordinates, and provides appropriate health education and counseling in response to client needs.

Competencies:

- Promotes the availability of information that meets client needs, promotes informed choice, provides rationale, and reflects the client's culture
- Provides education and counseling that is research-based and client-centered
- Supports the client in making positive behavioral changes
- Evaluates teaching strategies
- Assists clients to identify and use community and social resources
- Promotes the availability of educational materials in the language and reading level of the client

GUIDELINE IV. PROFESSIONAL ROLE

The women's health nurse practitioner contributes to the advancement of the profession, the evolving specialty role, and to practice.

Competencies

- Promotes client autonomy, dignity, and self-determination
- Establishes priorities and coordinates care to meet the needs of culturally diverse clients
- Develops, uses, and maintains collaborative relationships with health care professionals to strengthen the role of the women's health nurse practitioner
- Interprets and promotes the role of the nurse practitioner to consumers, other health care professionals, and the community
- Maintains awareness of developments in the field through membership in professional organizations or other means
- Aspires to serve as a role model, preceptor, and mentor to other nurse practitioners
- Influences the delivery of health care by nurse practitioners through participation in legislative and institutional policy making activities
- Participates in the generation, application, and dissemination of research
- Attains and maintains national certification

GUIDELINE V. MANAGING HEALTH CARE DELIVERY

The women's health nurse practitioner seeks to ensure high quality care within health care delivery systems. The practitioner demonstrates leadership skills in achieving improved health care outcomes for all clients.

Competencies:

- Uses nationally accepted guidelines and standards to promote integrated health care systems for the delivery of women's health care
- Provides case management services
- Participates in organizational decision making on issues that affect quality of health and efficient use of resources in the area of women's health
- Manages functions and resources within health care systems toward the provision of efficient and cost-effective quality care
- Collaborates with other health care professionals and recognizes the value of each provider's contribution to the comprehensive health care of women
- Acts as a resource in the planning, development, and implementation of community health programs
- Participates in legislative and policy making activities that influence women's health
- Acts as a consultant in specific areas of practice

GUIDELINE VI. QUALITY OF CARE

Women's health nurse practitioners are responsible for the care they provide. Accountability is demonstrated through the use of quality measures.

Competencies:

- Seeks to continuously improve client care
- Monitors self, peers, and the delivery system and strives for continuous improvement
- Assumes responsibility for maintaining competence as a women's health nurse practitioner
- Incorporates professional and legal standards and ethical principles into practice
- Uses research to enhance quality of care
- Participates in continuing education

EDUCATIONAL GUIDELINES

PHILOSOPHY AND OBJECTIVES

The women's health nurse practitioner education program should have a clear philosophy about the health care of women and the role of the nurse practitioner in the provision of this care. The health care market of the future will continue to be demanding clinically and economically. In order to provide a critical service for women, nurse practitioners must be able to compete in the dynamic market. This begins with clear definitions of both product and provider.

AWHONN and NANPRH recognize the movement from certificate programs to graduate level education for nurse practitioners. Nurse practitioners with a certificate, who are not yet prepared at the graduate level, should seek and be afforded opportunities to gain the additional education through creative educational programs. The 1995 Consensus Statement on Women's Health Care Nurse Practitioner Education provides a series of recommendations for a reasonable transition to the clear expectation that nurse practitioners have a masters degree.

The overall objective of the women's health nurse practitioner education program is to educate the individual for advanced nursing practice with emphasis on reproductive-gynecologic health and to prepare the practitioner to provide primary care to women across the life span. This education is based upon in-depth knowledge of theory, pathophysiology, pharmacotherapeutics, research utilization, outcome management principles, and clinical decision-making skills.

PROGRAM ORGANIZATION

Nurse practitioner programs should be based in a college or university where support of the program goals are demonstrated. Support includes the provision of adequate resources, offering the appropriate curriculum and program design, and faculty.

The duration of the women's health nurse practitioner education program should be at least one academic year (9 months). The program should include at least 250 didactic hours of nurse practitioner content and at least 600 hours of supervised clinical practice. Clinical hours should include a supervised preceptorship.

The faculty of the women's health nurse practitioner program should be multidisciplinary, and it is desirable that they be culturally diverse, with expertise in women's health and primary care. The majority of the faculty should be prepared as women's health nurse practitioners. To serve as both mentors and role models, the faculty should be currently certified

and maintain their competence through regular clinical practice. The director of the program should be a nurse practitioner prepared at the master's level or higher.

Clinical preceptors should be qualified by education and experience in the primary care of women or reproductive health. They should also be competent in clinical instruction. Use of nurse practitioners as preceptors is encouraged whenever possible. Preceptors may also include certified nurse-midwives and physicians. A faculty/student ratio of no greater than 1:2 is recommended for supervised clinical practice.

The women's health nurse practitioner program should have clear **admission criteria**. Qualified applicants should be admitted without regard to gender, race, disability, marital status, ethnic origin, creed, age, or sexual orientation. Selection and admission criteria should be established by the sponsoring institution and its nurse practitioner faculty. Programs should encourage enrollment and retention of nurses from culturally diverse populations.

Adequate classroom and clinical teaching facilities, administrative support, and teaching aids should be designated for the program. Students should have access to adequate library resources. Health care, counseling, and housing assistance should be available. Student records and program data should be kept in a manner that ensures confidentiality, retrievability, and permanence. Transcripts should be available upon student request.

PROGRAM CURRICULUM

The curriculum of the women's health nurse practitioner program should reflect the philosophy of the sponsoring institution. Curriculum content should prepare participants to meet standards of practice and enable graduates to be eligible for national certification. Teaching strategies should be based on the currently accepted theories and principles of adult education. To prepare competent women's health nurse practitioners to provide comprehensive care throughout the life span, the following content should be included:

I. GENERAL HEALTH ASSESSMENT

- Comprehensive or problem-focused health history
- Review of body systems
- Comprehensive physical examination
- Diagnostic studies and procedures
- Clinical decision making and critical thinking

II. GYNECOLOGY

- Reproductive anatomy, physiology, and endocrinology
- Reproductive pathophysiology
- Diagnostic studies and procedures
- Fertility control
- Infertility
- Perimenopause, menopause, and postmenopause
- Sexually transmitted infections, including HIV
- Gynecologic disorders
- Breast disorders

III. OBSTETRICS

- Embryology and fetal development
- Physiology of pregnancy and psychosocial aspects of pregnancy
- Preconceptional care
- Prenatal care
- Lactation assessment/support
- Complications of pregnancy
- Genetic disorders
- Assessment and management of high-risk pregnancy
- Diagnostic tests related to pregnancy
- Preparation for childbirth
- Intrapartum care
- Postpartum care

IV. COMMON (NONREPRODUCTIVE) HEALTH PROBLEMS

- HEENT (head, eyes, ears, nose, and throat) disorders
- Pulmonary disorders
- Integumentary disorders
- Musculoskeletal disorders
- Cardiovascular disorders
- Hematologic disorders
- Gastrointestinal disorders
- Genitourinary disorders
- Neurologic/mental disorders
- Endocrine and metabolic disorders
- Immune disorders

V. CLINICAL THERAPEUTICS

- Basic pharmacologic principles
- Principles of drug management
- Nonpharmacologic therapies
- Implications for clinical practice
- Federal and state regulations

VI. HEALTH MAINTENANCE AND DISEASE PREVENTION

- Theories of health and wellness
- Interviewing and communication skills
- Counseling techniques and crisis intervention
- Anticipatory guidance
- Teaching/learning principles
- Age-appropriate risk assessment, screening, and immunization
- Family dynamics and parenting
- Female role development throughout the lifespan
- Nutrition and eating disorders
- Physical fitness
- Mental health, anxiety, depression, and grief
- Human sexuality
- Violence and abuse
- Substance abuse
- Cultural variations that may affect care

VII. PROFESSIONAL ROLE

- Advanced practice role
- Legal and ethical issues
- Community outreach
- Issues related to women's health
- Health care policy
- Health care delivery systems
- Case management
- Legislative and regulatory issues
- Reimbursement systems and issues
- Research utilization

PROGRAM EVALUATION

The program should employ a variety of evaluation strategies to measure student achievement of nurse practitioner competencies. These strategies may include written tests and reports; classroom, laboratory, and clinical observation; self-assessments; conferences; and peer review. Evaluation should be ongoing, and students must be informed of their progress regularly.

There must be written policies regarding expected levels of achievement, probation, dismissal, and withdrawal. These policies should include expectations for the preceptorship and any time limits for completion of the program. A student grievance procedure must exist.

A regular, formal evaluation of the total educational program should be developed. Evaluation should be an integral part of the planning process and allow for timely change. Formative and summative evaluation is suggested and could include the following:

- Client, employer and practitioner needs assessment
- Program philosophy and goals
- Curriculum objectives and content
- Student outcomes
- Student-to-faculty ratios
- Faculty and clinical preceptor performance
- Clinical settings and experience

Graduates should be surveyed on both a short- and long-term basis to assess the program's impact on career development and role satisfaction as well as the graduates' impact on the delivery of women's health care. Sources of data and feedback to the program should include the following:

- Students
- Preceptors
- Faculty
- Graduates
- Employers
- Funding sources
- Clients
- Performance on certification examination

PROGRAM ACCREDITATION

External review and accreditation specific to the women's health nurse practitioner program should be conducted by a nationally recognized accreditation body. Accreditation is a process that recognizes nursing education programs that achieve a level of performance, quality, and integrity that entitles them to the confidence of the student consumer and the public. While basically a voluntary process, accreditation often is used as a criterion in decision making by funding organizations, state regulatory bodies, employers, and potential students. Because accreditation status is reviewed periodically, it encourages continuous self-study and improvement.

FOR MEMBERSHIP INFORMATION

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1-800-673-8499 ext. 1620
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NANPRH
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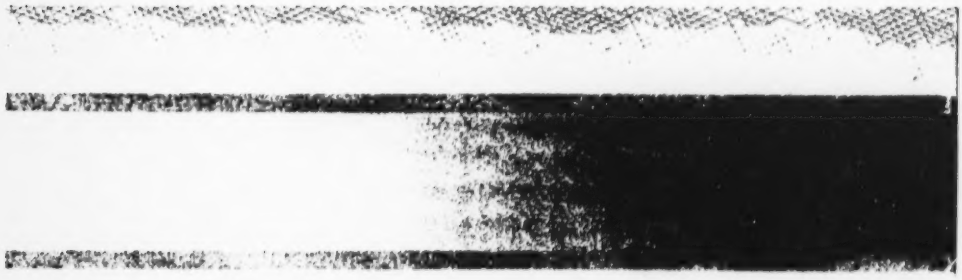
ASSOCIATION OF WOMEN'S HEALTH, OBSTETRIC AND NEONATAL NURSES (AWHONN)

Headquartered in Washington, D.C., the Association of Women's Health, Obstetric and Neonatal Nurses is a non-profit association of 22,000 nurses in the United States, Canada and abroad. The organization is dedicated to establishing and promoting the highest standards of nursing practice, education and research. AWHONN members are united in the common goal of fostering premium health care for women and newborns. They practice in hospitals, offices, home health and ambulatory care settings. The AWHONN membership strength comes from its rich diversity of skills, experience, and practice setting; and from its commitment to quality care. The association is considered *the voice* for women's health, obstetric and neonatal nursing care.

NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH (NANPRH)

Founded in 1980, the National Association of Nurse Practitioners in Reproductive Health is a non-profit membership organization. NANPRH is the only national organization exclusively representing nurse practitioners who practice in obstetrics, gynecology, family planning, reproductive endocrinology, and infertility. The organization's purpose is to assure quality reproductive health services and to promote the delivery of these services by nurse practitioners. NANPRH is the accrediting body of women's health nurse practitioner programs. NANPRH's members practice in a variety of settings, including public health, community health, hospitals, family planning clinics, student health services, health maintenance organizations and private practice.



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APPENDIX E

American College of Nurse-Midwives. (1997). *Core Competencies for Basic Midwifery Practice.* Washington, DC: Author.

Reprinted with permission from American College of Nurse-Midwives.

This document is included here as an example of guidelines and competencies developed for specialized graduate nursing education in women's health.

AMERICAN COLLEGE OF NURSE-MIDWIVES

THE CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE MAY 1997

The core competencies for basic midwifery practice represent the delineation of the fundamental knowledge, skills, and behaviors expected of a new practitioner; as such, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy-makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited by the American College of Nurse-Midwives (ACNM).[†]

Midwifery practice is based on the *Core Competencies for Basic Midwifery Practice, The Standards for the Practice of Nurse-Midwifery* and the *Code of Ethics* promulgated by the American College of Nurse-Midwives. Midwives who have been certified by the ACNM or the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary care providers.

Midwifery education is based on a theoretical foundation in the health sciences as well as clinical preparation which focuses on the knowledge, judgment, and skills deemed necessary to provide primary care and independent management of women and newborns within a health care system, that provides for medical consultation, collaborative management, or referral as appropriate. Recognizing that creativity, innovation, and individuality, are essential to the vitality of the profession, each education program may develop its own unique identity and may choose to extend beyond the core competencies into other areas of health care. In addition, each graduate is responsible for complying with the of the jurisdiction where the practice of midwifery is conducted.

The ACNM defines the midwife's role in primary care based on the Institute of Medicine's definition (1994), the ACNM's Philosophy(1989), and the ACNM Board of Directors' Position Statement on Primary Care by Nurse-Midwives (1992). Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. Certified nurse-midwives (CNMs) and certified midwives (CMs) are often the initial contact for providing health care to women and they provide such care on a continuous and comprehensive basis. As a primary provider, the CNM or CM assumes responsibility for the provision of and referral for appropriate services within a defined scope of practice.

The concepts and skills identified below and the midwifery management process outlined in the sections that follow apply to all components of midwifery care and comprise the foundation upon which practice guidelines and curriculum content must be built. This document is reviewed and revised at least every five years to reflect changing trends and new developments in midwifery practice and must be adhered to in its entirety.

Hallmarks of Midwifery

The art and science of midwifery are characterized by these hallmarks:

- Recognition of pregnancy and birth as a normal physiologic and developmental process and advocacy of non-intervention in the absence of complications
- Recognition of menses and menopause as a normal physiologic and developmental process
- Promotion of family-centered care empowerment of women as partners in health care
- Facilitation of healthy family and interpersonal relationships
- Promotion of continuity of care

[†] Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or ACNM Certification Council, Inc. (ACC).

- Health promotion, disease prevention and health education
- Advocacy for informed choice, participatory decision-making, and the right to self-determination
- Cultural competency and proficiency
- Skillful communication, guidance, and counseling
- Therapeutic value of human presence
- Value of and respect for differing paths toward knowledge and growth
- Effective communication and collaboration with other members of the health care team
- Promotion of a public health care perspective
- Care to vulnerable populations

Components of Midwifery Care: Professional Responsibilities of CNMs and CMS

The professional responsibilities of CNMs and CMS include, but are not limited to, these components:

- Knowledge of the history of midwifery
- Knowledge of the legal basis for practice
- Knowledge of national and international issues and trends in women's health and maternal/newborn care
- Support of legislation and initiatives to promote high quality health care services
- Knowledge of issues and trends in health care policy and systems
- Commitment to the ACNM's Philosophy, Standards, and Code of Ethics
- Participation in midwifery education
- Systematic collection of practice data to document midwifery care outcomes
- Ability to evaluate, apply, interpret, and collaborate in research
- Participation in self-evaluation, peer review, continuing education, and other activities that ensure and validate quality practice
- Development of leadership skills

Components of Midwifery Care: Midwifery Management Process

The midwifery management process includes:

- Systematically compiling and updating a complete and relevant data base for the comprehensive assessment of each client's health, including a thorough health history and physical examination
- Identifying problems and formulating diagnoses based upon interpretation of the data base
- Identifying health care needs/problems and establishing health care goals in collaboration with the client
- Providing information and support to enable women to make informed decisions and to assume primary responsibility for their own health
- Developing a comprehensive plan of care with the client
- Assuming primary responsibility for the implementation of individualized plans
- Obtaining consultation, planning and implementing collaborative management, and referral or transferring the care of the client as appropriate
- Initiating management of specific complications, emergencies and deviations from normal
- Evaluating, with the client, the achievement of health care goals and modifying the plan of care as appropriate

Components of Midwifery Care: The Childbearing Family

I. **Pre-Conception Care**

A. Independently manages care of the woman who is preparing for pregnancy

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

©American College of Nurse-Midwives, 1997 - *The Core Competencies for Basic Midwifery Practice*

1. Reproductive anatomy and physiology related to conception

2. Impact of health, family and genetic history on pregnancy outcomes

3. Health and laboratory screening to evaluate the potential for a healthy pregnancy

4. Assessment of readiness for pregnancy of the woman and her family including emotional, psychosocial, and sexual factors

5. Nutritional assessment and counseling

6. Influence of environmental and occupational factors, health habits, and behavior on pregnancy planning

II. Care of the Childbearing Woman

A. Independently manages care of the woman during pregnancy, childbirth, and the postpartum period

B. Applies knowledge of midwifery practice in the antepartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of conception, pregnancy and lactation

2. Diagnosis of pregnancy

3. Genetics, placental physiology, embryology, and fetal development

4. Epidemiology of maternal and perinatal morbidity and mortality

5. Influence of environmental and occupational factors, health habits, and maternal behaviors on pregnancy outcomes

6. Emotional and psychosexual change during pregnancy

7. Health risks including domestic violence, sexually transmitted diseases, substance, alcohol and tobacco use

8. Effect of maternal nutrition on pregnancy outcomes

9. Indicators of normal pregnancy and deviations from normal

10. Assessment of the progress of pregnancy and fetal well-being

11. Etiology and management of common discomforts of pregnancy

12. Management techniques and therapeutics, including complementary therapies**

13. Anticipatory guidance related to birth, lactation, parenthood, and change in the family constellation

14. Pharmacokinetics and pharmacotherapeutics of medications commonly used during pregnancy

15. Principles of group education

C. Applies knowledge of midwifery practice in the intrapartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of the structures and processes of labor

2. Anatomy and physiology of the fetus

** Complementary therapies as used throughout this document refer to those therapeutic measures for which there is some evidence of safety and effectiveness.

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3. Diagnosis and assessment of labor and its progress through the four stages.

4. Assessment of maternal and fetal status during labor

5. Indicators of deviation from normal including complications and emergencies

6. Measures to support psychosocial needs during labor and delivery

7. Management techniques and therapeutics, including complementary therapies, to facilitate normal labor progress

8. Techniques for (I) administration of local anesthesia, including pudendal blocks, (ii) spontaneous vaginal delivery, (iii) third stage management, and (iv) performance and repair of episiotomy and repair of lacerations

9. Techniques for management of emergency complications and abnormal birth events

10. Pharmacokinetics and pharmacotherapeutics of medications commonly used during labor and birth

D. Applies knowledge of midwifery practice in the postpartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of the puerperium

2. Emotional, psychosocial, and sexual changes of the puerperium

3. Postpartum self-care, infant care, contraception, and family relationships

4. Management techniques and therapeutics, including complementary therapies, to facilitate a healthy puerperium

5. Methods of facilitation or suppression of lactation

6. Deviations from normal and appropriate interventions including management of complications and emergencies

7. Management of discomforts of the puerperium

8. Pharmacokinetics and pharmacotherapeutics of medications commonly used during the puerperium

III. Newborn Care

A. Independently manages the care of the newborn

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Effect of maternal/fetal risk factors on the newborn

2. Anatomy and physiology of the newborn

3. Nutritional needs of the newborn

4. Bonding and attachment theory

5. Evaluation on neonatal status: (I) Physical and behavioral assessment, (ii) gestational age assessment, and (iii) common screening and diagnostic tests performed on the neonate

6. Methods to facilitate adaptation to extrauterine life: (I) stabilization at birth, (ii) resuscitation, and (iii) emergency management

7. Promotion and management of breastfeeding

8. Indications of deviation from normal and appropriate interventions

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9. Management techniques to facilitate integration of the newborn into the family

10. Pharmacokinetics and pharmacotherapeutics of common medications used in the neonatal period

Components of Midwifery Care: The Primary Care of Women

I. Health Promotion and Disease Prevention

A. Independently manages primary health screening of women through the life cycle

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology

2. Growth and development patterns for the woman across the life span

3. Basic principles of clinical epidemiology as they affect women's health

4. National defined goals and objectives for health promotion and disease prevention

5. Parameters for assessment of physical and mental health

6. Utilization of nationally defined screening recommendations to promote health and detect/prevent disease

7. Management techniques and therapeutics, including complementary therapies, to facilitate health

8. Pharmacokinetics and pharmacotherapeutics of immunizations

II. Management of Common Health Problems

A. Assumes responsibility for the triage of common health problems presented by women and for management, collaboration, co-management and/or referral to appropriate levels of health care services within the CNM's or CM's defined scope of practice

B. Applies the knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and pathophysiology related to frequently occurring conditions

2. Etiology of common health problems of essentially healthy women

3. Parameters for differential diagnosis of common presenting health problems

4. Management techniques and therapeutics, including complementary therapies, for the treatment of common health problems of essentially healthy women

5. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for common health problems

6. Skills in health care team leadership and management to ensure that presenting health care concerns are addressed completely by a multi-disciplinary health care team and community services

III. Family Planning /Gynecologic Care

A. Independently manages the care of women seeking family planning and/or gynecologic services

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

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1. Anatomy and physiology of the reproductive system, including the breast, through the life cycle

2. Human sexuality

3. Common screening and diagnostic tests

4. Parameters for differential diagnosis of common gynecologic problems including sexually transmitted diseases

5. Essentials of barrier, hormonal, mechanical, chemical, physiologic, and surgical conception control methods

6. Management techniques and therapeutics, including complementary therapies, for common gynecologic problems and family planning needs

7. Counseling for sexual behaviors that promote health and prevent disease

8. Resources for counseling and referral for unplanned or undesired pregnancies, sexual concerns, infertility, and other gynecologic problems

9. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for family planning and gynecologic care

IV. Perimenopause and Post-Menopause

A. Independently manages the care of women during the perimenopause and postmenopause

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology of the systems as affected by the aging process

2. The effects of the menopause on physical and mental health

3. Nutritional needs of the aging woman

4. Common screening and diagnostic tests pertinent to the evaluation of the health of women with advancing age

5. Identification of deviations from normal and appropriated interventions

6. Counseling and education for health maintenance and health promotion in the aging woman

7. Management techniques and therapeutics, including complementary therapies, for alleviating the common discomforts that accompany aging

8. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications and treatments for the perimenopausal and menopausal woman

Source: Education Section, Division of Education
Approved by the ACNM Board of Directors
May 31, 1997

(Supersedes ACNM *Core Competencies for Basic Midwifery Practice*, February 1992)

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AMERICAN COLLEGE OF NURSE-MIDWIVES

THE CORE COMPETENCIES FOR BASIC MIDWIFERY PRACTICE MAY 1997

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The concepts and skills identified below and the midwifery management process outlined in the sections that follow apply to all components of midwifery care and comprise the foundation upon which practice guidelines and curriculum content must be built. This document is reviewed and revised at least every five years to reflect changing trends and new developments in midwifery practice and must be adhered to in its entirety.

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- Recognition of menses and menopause as a normal physiologic and developmental process
- Promotion of family-centered care empowerment of women as partners in health care
- Facilitation of healthy family and interpersonal relationships
- Promotion of continuity of care

[†] Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or ACNM Certification Council, Inc. (ACC).

- Health promotion, disease prevention and health education
- Advocacy for informed choice, participatory decision-making, and the right to self-determination
- Cultural competency and proficiency
- Skillful communication, guidance, and counseling
- Therapeutic value of human presence
- Value of and respect for differing paths toward knowledge and growth
- Effective communication and collaboration with other members of the health care team
- Promotion of a public health care perspective
- Care to vulnerable populations

Components of Midwifery Care: Professional Responsibilities of CNMs and CMS

The professional responsibilities of CNMs and CMS include, but are not limited to, these components:

- Knowledge of the history of midwifery
- Knowledge of the legal basis for practice
- Knowledge of national and international issues and trends in women's health and maternal/newborn care
- Support of legislation and initiatives to promote high quality health care services
- Knowledge of issues and trends in health care policy and systems
- Commitment to the ACNM's Philosophy, Standards, and Code of Ethics
- Participation in midwifery education
- Systematic collection of practice data to document midwifery care outcomes
- Ability to evaluate, apply, interpret, and collaborate in research
- Participation in self-evaluation, peer review, continuing education, and other activities that ensure and validate quality practice
- Development of leadership skills

Components of Midwifery Care: Midwifery Management Process

The midwifery management process includes:

- Systematically compiling and updating a complete and relevant data base for the comprehensive assessment of each client's health, including a thorough health history and physical examination
- Identifying problems and formulating diagnoses based upon interpretation of the data base
- Identifying health care needs/problems and establishing health care goals in collaboration with the client
- Providing information and support to enable women to make informed decisions and to assume primary responsibility for their own health
- Developing a comprehensive plan of care with the client
- Assuming primary responsibility for the implementation of individualized plans
- Obtaining consultation, planning and implementing collaborative management, and referral or transferring the care of the client as appropriate
- Initiating management of specific complications, emergencies and deviations from normal
- Evaluating, with the client, the achievement of health care goals and modifying the plan of care as appropriate

Components of Midwifery Care: The Childbearing Family

I. Pre-Conception Care

A. Independently manages care of the woman who is preparing for pregnancy

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

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1. Reproductive anatomy and physiology related to conception

2. Impact of health, family and genetic history on pregnancy outcomes

3. Health and laboratory screening to evaluate the potential for a healthy pregnancy

4. Assessment of readiness for pregnancy of the woman and her family including emotional, psychosocial, and sexual factors

5. Nutritional assessment and counseling

6. Influence of environmental and occupational factors, health habits, and behavior on pregnancy planning

II. Care of the Childbearing Woman

A. Independently manages care of the woman during pregnancy, childbirth, and the postpartum period

B. Applies knowledge of midwifery practice in the antepartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of conception, pregnancy and lactation

2. Diagnosis of pregnancy

3. Genetics, placental physiology, embryology, and fetal development

4. Epidemiology of maternal and perinatal morbidity and mortality

5. Influence of environmental and occupational factors, health habits, and maternal behaviors on pregnancy outcomes

6. Emotional and psychosexual change during pregnancy

7. Health risks including domestic violence, sexually transmitted diseases, substance, alcohol and tobacco use

8. Effect of maternal nutrition on pregnancy outcomes

9. Indicators of normal pregnancy and deviations from normal

10. Assessment of the progress of pregnancy and fetal well-being

11. Etiology and management of common discomforts of pregnancy

12. Management techniques and therapeutics, including complementary therapies**

13. Anticipatory guidance related to birth, lactation, parenthood, and change in the family constellation

14. Pharmacokinetics and pharmacotherapeutics of medications commonly used during pregnancy

15. Principles of group education

C. Applies knowledge of midwifery practice in the intrapartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of the structures and processes of labor

2. Anatomy and physiology of the fetus

** Complementary therapies as used throughout this document refer to those therapeutic measures for which there is some evidence of safety and effectiveness.

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3. Diagnosis and assessment of labor and its progress through the four stages.

4. Assessment of maternal and fetal status during labor

5. Indicators of deviation from normal including complications and emergencies

6. Measures to support psychosocial needs during labor and delivery

7. Management techniques and therapeutics, including complementary therapies, to facilitate normal labor progress

8. Techniques for (I) administration of local anesthesia, including pudendal blocks, (ii) spontaneous vaginal delivery, (iii) third stage management, and (iv) performance and repair of episiotomy and repair of lacerations

9. Techniques for management of emergency complications and abnormal birth events

10. Pharmacokinetics and pharmacotherapeutics of medications commonly used during labor and birth

D. Applies knowledge of midwifery practice in the postpartum period that includes, but is not limited to, the following:

1. Anatomy and physiology of the puerperium

2. Emotional, psychosocial, and sexual changes of the puerperium

3. Postpartum self-care, infant care, contraception, and family relationships

4. Management techniques and therapeutics, including complementary therapies, to facilitate a healthy puerperium

5. Methods of facilitation or suppression of lactation

6. Deviations from normal and appropriate interventions including management of complications and emergencies

7. Management of discomforts of the puerperium

8. Pharmacokinetics and pharmacotherapeutics of medications commonly used during the puerperium

III. Newborn Care

A. Independently manages the care of the newborn

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Effect of maternal/fetal risk factors on the newborn

2. Anatomy and physiology of the newborn

3. Nutritional needs of the newborn

4. Bonding and attachment theory

5. Evaluation on neonatal status: (I) Physical and behavioral assessment, (ii) gestational age assessment, and (iii) common screening and diagnostic tests performed on the neonate

6. Methods to facilitate adaptation to extrauterine life: (I) stabilization at birth, (ii) resuscitation, and (iii) emergency management

7. Promotion and management of breastfeeding

8. Indications of deviation from normal and appropriate interventions

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9. Management techniques to facilitate integration of the newborn into the family

10. Pharmacokinetics and pharmacotherapeutics of common medications used in the neonatal period

Components of Midwifery Care: The Primary Care of Women

I. Health Promotion and Disease Prevention

A. Independently manages primary health screening of women through the life cycle

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology

2. Growth and development patterns for the woman across the life span

3. Basic principles of clinical epidemiology as they affect women's health

4. National defined goals and objectives for health promotion and disease prevention

5. Parameters for assessment of physical and mental health

6. Utilization of nationally defined screening recommendations to promote health and detect/prevent disease

7. Management techniques and therapeutics, including complementary therapies, to facilitate health

8. Pharmacokinetics and pharmacotherapeutics of immunizations

II. Management of Common Health Problems

A. Assumes responsibility for the triage of common health problems presented by women and for management, collaboration, co-management and/or referral to appropriate levels of health care services within the CNM's or CM's defined scope of practice

B. Applies the knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and pathophysiology related to frequently occurring conditions

2. Etiology of common health problems of essentially healthy women

3. Parameters for differential diagnosis of common presenting health problems

4. Management techniques and therapeutics, including complementary therapies, for the treatment of common health problems of essentially healthy women

5. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for common health problems

6. Skills in health care team leadership and management to ensure that presenting health care concerns are addressed completely by a multi-disciplinary health care team and community services

III. Family Planning /Gynecologic Care

A. Independently manages the care of women seeking family planning and/or gynecologic services

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

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1. Anatomy and physiology of the reproductive system, including the breast, through the life cycle

2. Human sexuality

3. Common screening and diagnostic tests

4. Parameters for differential diagnosis of common gynecologic problems including sexually transmitted diseases

5. Essentials of barrier, hormonal, mechanical, chemical, physiologic, and surgical conception control methods

6. Management techniques and therapeutics, including complementary therapies, for common gynecologic problems and family planning needs

7. Counseling for sexual behaviors that promote health and prevent disease

8. Resources for counseling and referral for unplanned or undesired pregnancies, sexual concerns, infertility, and other gynecologic problems

9. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications for family planning and gynecologic care

IV. Perimenopause and Post-Menopause

A. Independently manages the care of women during the perimenopause and postmenopause

B. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

1. Anatomy and physiology of the systems as affected by the aging process

2. The effects of the menopause on physical and mental health

3. Nutritional needs of the aging woman

4. Common screening and diagnostic tests pertinent to the evaluation of the health of women with advancing age

5. Identification of deviations from normal and appropriated interventions

6. Counseling and education for health maintenance and health promotion in the aging woman

7. Management techniques and therapeutics, including complementary therapies, for alleviating the common discomforts that accompany aging

8. Pharmacokinetics and pharmacotherapeutics of frequently prescribed medications and treatments for the perimenopausal and menopausal woman

Source: Education Section, Division of Education
Approved by the ACNM Board of Directors
May 31, 1997

(Supersedes ACNM *Core Competencies for Basic Midwifery Practice*, February 1992)

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APPENDIX F

Advisory Group for Women's Health Baccalaureate Nursing Curriculum Project.

Advisory Group for Women's Health Baccalaureate Nursing Curriculum Project

Dyanne Affonso, PhD, RN, FAAN
Advisory Committee for the Office of Research on Women's Health
National Institutes of Health &
Asian American Pacific Island Nursing Association

Geraldine (Polly) Bednash, PhD, RN, FAAN*
Executive Director
American Association of Colleges of Nursing

Deborah Danoff, MD
Assistant Vice-President
Division of Medical Education
Association of American Medical Colleges

Janet B. Henrich, MD*
Director, Woman's Health Program
Yale School of Medicine &
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Judith Lewis, PhD, RN, FAAN*
Association of Women's Health, Obstetric and Neonatal Nurses, and American Academy of Nursing

Martha Kelly, EdD, RN*
Manager, Education Councils
National League for Nursing

Susan Mattson, RNC, PhD*
Nurse Scholar
Office of Behavioral & Social Sciences Research
National Institute of Nursing Research
National Institutes of Health

Angela McBride, PhD, RN, FAAN*
Dean, School of Nursing
Indiana University &
Advisory Committee for the Office of Research on Woman's Health
National Institutes of Health

Thomas Pepler*
Vice President
National Student Nurses' Association

Nilda Peragallo, DrPH, RN
National Association of Hispanic Nurses

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Roxanne Struthers, MS, RN*
National Alaska Native American Indian Nurses Association

Nancy F. Woods, PhD, RN, FAAN*
Dean, School of Nursing
University of Washington &
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National Institutes of Health

Susan Wysocki*
President/Executive Director
National Association of Nurse Practitioners in Reproductive Health

Federal Agency Representatives

Denise Geolot, PhD, RN, FAAN*
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Health Resources and Services Administration

Betty Hambleton*
Senior Advisor, Women's Health
Health Resources and Services Administration
Department of Health and Human Services

Diedra Henry*
Staff Assistant for Violence Against Women Issues
Office on Women's Health, Department of Health and Human Services

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Vivian W. Pinn, MD*
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Irene Sandvold, DrPH, CNM, FACNM*
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Susan Wood, PhD
Deputy Director, Office on Women's Health
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Project Staff

Joan Stanley, PhD, RN, CRNP*
Project Director
Director of Education Policy
American Association of Colleges of Nursing

Frances Weed, RN, MSN*
Director of Special Projects
American Association of Colleges of Nursing

Emily Schmid
Education Policy and Program Assistant
American Association of Colleges of Nursing

* Attended the Advisory Group Meeting held in Washington, DC in December, 1998

APPENDIX G

Cover Letter and Survey Instrument

American Association of Colleges of Nursing Survey, *Women's Health in the Baccalaureate Nursing Curriculum Questionnaire*

August 10, 1999

«name», «degree», «title»
«inst»
«add1»
«add2»
«add3»
«city», «st» «zip»«zip2»

Dear Dr. «surname»:

I am writing to request your participation in AACN's *Women's Health Content in Baccalaureate Level Nursing Education Programs* project. This project is supported by five collaborating partners: the Division of Nursing, Bureau of Health Professions, HRSA, U.S. DHHS; the Office of the HRSA Senior Advisor for Women's Health; the Office of Research on Women's Health; the National Institute of Nursing Research; and the U.S. Public Health Service's Office on Women's Health.

The project will describe women's health content in bachelor's-degree nursing education programs, cite best practices, and recommend strategies for strengthening women's health perspectives in preparing entry-level baccalaureate nurses. As a first phase of the project, AACN is conducting a survey to identify women's health curricular content in entry-level baccalaureate nursing education programs. The collaborating partners will subsequently support analyses of the data being collected by AACN and preparation of the report.

This women's health initiative will complement work already completed by HRSA, ORWH, and OWH in response to a congressional directive to examine the academic and clinical training of health professionals and recommend strategies for integrating women's health into the curriculum. The first stages of the federal initiative focused on the medical and dental school curricula. As part of its analyses, AACN will attempt to correlate findings with those of the medical and dental school curricula surveys.

Kindly forward the enclosed survey to the individual in the school of nursing who is most knowledgeable about the baccalaureate nursing curriculum so that he/she can complete and return the competed survey by **Wednesday, September 15**. A stamped, self-addressed return envelope is enclosed for your convenience.

I am acutely aware of the effort required for this task; therefore, I would like to thank you and your staff in advance for your time in completing this survey. Once it is completed the final project report will be published by the federal partners; and therefore, will be made available to you.

Sincerely,

Joan M. Stanley

Joan Stanley, PhD, RN, CRNP
Director of Education Policy

Enclosures (2)

American Association of Colleges of Nursing
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Washington, DC 20036-1120
(202) 463-6930
FAX: (202) 785-8320
E-mail: jstanley@aacn.nche.edu
http://www.aacn.nche.edu

PLEASE CORRECT ABOVE INFORMATION

WOMEN'S HEALTH IN THE BACCALAUREATE NURSING CURRICULUM QUESTIONNAIRE

Please forward this survey to the individual in the school of nursing who is most knowledgeable about the baccalaureate nursing curriculum!

Contact person for questions about this form:
Area Code/Number/Extension:
E-mail:

Definition of women's health: The term "women's health" refers to wellness and illness issues that are unique to or more prevalent or serious in women, have causes or manifestations specific to women, have outcomes or intervention processes specific to women, and occur across the lifespan and within the context of women's lives. Such context includes but is not limited to:

- Environment
- Social status
- Economic class
- Political belief and/or affiliation
- Ethnicity
- Cultural background
- Developmental stage
- Biologic and/or genetic makeup
- Spirituality

Definition of baccalaureate nursing curriculum: For the purpose of this survey, the undergraduate nursing curriculum includes all didactic and clinical coursework or experiences required or offered by the school of nursing, including pre-requisites. If a course taught outside of the school of nursing is required or strongly recommended for graduation from the baccalaureate nursing program it should be included.

A. GENERAL QUESTIONS

1. Does your school of nursing have an Office of Women's Health or dedicated program personnel responsible for ensuring the integration of women's health and gender-related issues into the curriculum? (Circle one)

1 - Yes
2 - No
3 - Don't know

2. Does your school of nursing have specific mechanisms to assist faculty in increasing their competence in women's health and in incorporating women's health and gender-related issues into their teaching? (Circle one) If yes, please describe.

1 - Yes (describe) _____
2 - No
3 - Don't know

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3. Does your nursing school have a women's health care center? (Circle one)

1 - Yes
2 - No
3 - Don't know

4. Is there a women's health care center on campus or at your institution?

1 - Yes
2 - No
3 - Don't know

5. Does your campus/institution have a federally funded center of excellence in women's health?

1 - Yes
2 - No
3 - Don't know

→ **5b. If yes, what school or discipline runs the center of excellence?**

1 - School of Medicine
2 - School of Nursing
3 - Both School of Medicine and School of Nursing
4 - Other (specify) _____

6. Does your school of nursing offer a graduate program with a major in women's health?

1 - Yes
2 - No
3 - Don't know

→ **6b. If yes, circle all programs offered:**

1 - Women's Health or OB/Gyn NP program
2 - Nurse Midwifery Program
3 - CNS program with a major in women's health

7a. In the '98 – '99 academic year, how many of the full-time school of nursing faculty were nationally certified/state recognized as women's health nurse practitioners? _____

7b. In the '98 – '99 academic year, how many of the full-time school of nursing faculty were certified nurse-midwives? _____

7c. Excluding women's health nurse practitioners and certified nurse-midwives, in the '98 – '99 academic year, how many of the full-time school of nursing faculty had a minimum of a master's degree with a specialization in a women's health field, e.g. perinatal or maternal/child nursing? _____

8. Based on the above definition of Women's Health, does your baccalaureate nursing curriculum place a: (Circle one)

1 - Major emphasis on women's health
2 - Minor emphasis on women's health
3 - Unclear or no emphasis on women's health

9. Did your school use the Healthy People 2000 objectives in the curriculum planning/review process? (Circle one)

1 - Yes
2 - No
3 - Don't know

B. PLEASE USE THE FOLLOWING DESCRIPTIVE CATEGORIES TO INDICATE HOW EACH OF THE FOLLOWING TOPICS IS INCLUDED IN YOUR BACCALAUREATE NURSING CURRICULUM:

Descriptive Categories:
1st column:
The content is taught:
1 = as part of an existing required course(s);
2 = as a separate required course;
3 = as an elective course; or
4 = not offered or included in baccalaureate nursing curriculum.

2nd column:
***Primary* format(s) used to present the information? (If the contact is presented in a combination of formats you may select all that apply.)**
1 = lecture
2 = small group discussion/seminar
3 = clinical practicum
4 = self-study

3rd column:
Who is *primarily* responsible for teaching the content or topics listed? (If more than one individual teaches the content you may select all that apply.)
1 = Nurse faculty who is a CNM, a WHNP or a CNS w/ a specialty in a WH field
2 = Other nursing faculty without specialization in women's health
3 = Physician
4 = Psychologist
5 = Pharmacist
6 = Other

	The content is taught: **1** = as part of an existing required course; **2** = as a separate required course; **3** = as an elective course; or **4** = not offered or included in baccalaureate nursing curriculum.				***Primary* format(s) used to present the information?** **1** = lecture **2** = small group discussion/seminar **3** = clinical practicum **4** = self-study				**Who is *primarily* responsible for teaching the content or topics listed?** **1** = Nurse faculty who is a CNM, a WHNP or CNS w/ specialty in WH field **2** = Other nursing faculty without specialization in women's health **3** = Physician **4** = Psychologist **5** = Pharmacist **6** = Other					
General Topics:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
The impact of gender on health issues across the life stages	1	2	3	4	1	2	3	4	1	2	3	4	5	6
The impact of race/ethnicity/culture on health status, health beliefs and behaviors, and health care utilization	1	2	3	4	1	2	3	4	1	2	3	4	5	6
The impact of spirituality on health status, health beliefs and behaviors, and health care utilization	1	2	3	4	1	2	3	4	1	2	3	4	5	6
The impact of poverty/socioeconomic status on health status and access to health care	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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Biologic Considerations:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Normal and abnormal female anatomy & physiology	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Female reproductive biology	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Genetic influences on health risks of women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Sex/gender differences in pathogenesis of disease and disease mechanisms	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Sex/gender differences in epidemiology of disease and disease rates	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Gender differences in pharmacokinetics of drugs	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Sex/gender differences on development across the life span	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Sex/gender differences in biologic aging process	1	2	3	4	1	2	3	4	1	2	3	4	5	6

Developmental and psychosocial issues:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Milestones in the developmental process of women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Physiologic effects of reproductive hormones across the lifespan of females	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Psycho/social effects of reproductive hormones across the lifespan of females	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Integrated biologic/psycho/social effects of reproductive hormones across the lifespan of females	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Pubertal development and changing health issues in young women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Gender identification and sexual orientation	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Impact of societal role expectations on women's health	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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Developmental and psychosocial issues, continued:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Health consequences of traumas experienced by women:														
Childhood sexual/physical/emotional abuse	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Domestic violence	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Rape	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Other criminal victimization	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Discrimination/oppression	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Workplace harassment	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Influence of sex/gender on the following conditions:														
Anxiety disorders (panic/phobias)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Depressive syndromes	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Eating behaviors/disorders	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Addictive behaviors/disorders	1	2	3	4	1	2	3	4	1	2	3	4	5	6

Approaches to health behaviors/health promotion in women:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Adaptation to stress	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Physical fitness and weight management	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Nutrition	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Reproductive decision-making	1	2	3	4	1	2	3	4	1	2	3	4	5	6
HIV/AIDS and prevention of risk	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Other STDs and prevention of risk	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Intentional and unintentional self-inflicted injuries, e.g. suicide	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Tobacco use and cessation	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Effect of tobacco on women's health, particularly the reproductive tract and osteoporosis	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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Approaches to health behaviors/health promotion in women, continued:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Alcohol use/abuse	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Prescription drug abuse	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Other substance use/abuse	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Prevalence, pathophysiology, assessment, medical/nursing management and prevention of:														
Lung cancer in women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Breast cancer in women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Colorectal cancer in women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Cancers specific to women (e.g. ovarian, uterine, cervical)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Cardiovascular risk prevention and screening	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Occupational/environmental health hazards	1	2	3	4	1	2	3	4	1	2	3	4	5	6

Sexual and Reproductive Functioning at various life stages:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Normal menstruation	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Contraception and fertility management	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Intended/unintended pregnancy	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Preconception and interconceptional health practices (Getting to pregnancy in optimal health)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Use of folic acid/folate to decrease incidence of spina bifida	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Sequelae of infertility	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Sexuality	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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The etiology, prevalence, course, treatment and prevention of common health problems of the reproductive tract:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Breast health	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Benign breast disorders	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Endometriosis	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Fibroids	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Pelvic inflammatory disease	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Vaginal infections	1	2	3	4	1	2	3	4	1	2	3	4	5	6

The etiology, prevalence, course, treatment, and prevention of the following conditions *SPECIFICALLY IN WOMEN:*	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Cardiovascular disease	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Coronary artery disease	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Stroke syndromes	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Hypertension	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Lipoprotein disorders	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Diabetes	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Obesity	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Immunologic diseases (e.g. SLE, RA, Scleraderma)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Respiratory disorders (e.g., COPD, Asthma)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Osteoporosis	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Osteoarthritis	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Migraine/other headache disorders	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Temporomandibular joint disease	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Urinary incontinence	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Urinary tract infection	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Interstitial cystitis	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Fibromyalgia and chronic fatigue syndrome	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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The etiology, prevalence, course, treatment, and prevention of the following conditions *SPECIFICALLY IN WOMEN*, continued:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Inflammatory bowel disorders (e.g. Crohn's, ulcerative colitis)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Functional bowel disorders	1	2	3	4	1	2	3	4	1	2	3	4	5	6

Health Assessment and Teaching:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Taking a reproductive history	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Taking a sexual history	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Obtaining history of traumatic events (e.g., domestic violence, rape, incest)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Understanding gender influences on patient/health provider relationship	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Understanding cultural background influences on patient/health provider relationship	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Cultural competence in communicating with women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Patient education/teaching appropriate to the age, gender, and cultural status of women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Patient teaching and the application to nursing interventions for:														
Endometrial biopsy	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Cervical (Pap) smears/biopsy	1	2	3	4	1	2	3	4	1	2	3	4	5	6
HIV/AIDS in women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Other STDs in women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Domestic violence protocol	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Common diagnostic testing done during pregnancy	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Assessment and symptom management issues related to:														
Sleep	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Fatigue	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Pain	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Mobility	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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Selected Topics:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Women's health issues within and across cultural/ethnic groups	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Women's health and socioeconomic issues	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Women's health and spirituality issues	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Health issues of elderly women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Lesbian health issues	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Health issues for women with disabilities	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Gender specific health care decision-making	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Gendered nature of health care and nursing	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Gender specific communication styles	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Effects of gender discrimination and sexual harassment	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Women as providers, consumers, decision-makers and caregivers in families	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Issues of empowerment at the individual and professional level	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Homelessness of women	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Loss of spouse	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Loss of a child	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Accessing community resources sensitive to women's health care needs (e.g. shelters, safe houses, legal resources)	1	2	3	4	1	2	3	4	1	2	3	4	5	6

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Legal and ethical issues:	**(Circle one)**				**(Circle all that apply)**				**(Circle all that apply)**					
Health policy implications on women's health (e.g. family/medical leave, insurance)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Gender related differences in access to health services due to differences in insurance, economic resources	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Legal issues surrounding rights of women (e.g., abortion, workplace discrimination)	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Ethical issues of women in medical research, including enrollment in clinical trials	1	2	3	4	1	2	3	4	1	2	3	4	5	6
Awareness of research on women/minority health	1	2	3	4	1	2	3	4	1	2	3	4	5	6

Thank you for completing this survey!
Please return it in the enclosed self-addressed stamped envelope or fax to 202-785-8320 no later than Wednesday, September 15, 1999!

Optional: If you have a women's health baccalaureate nursing course description or syllabus that you would like to share with us please enclose when you return survey or send under separate cover to:

Joan Stanley, PhD, RN, CRNP
One Dupont Circle NW, Suite 530
Washington, DC 20036

women/women3.doc

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APPENDIX H

Project Staff List

PROJECT STAFF

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OTHER CONTRIBUTORS

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APPENDIX I

Order Form for Office of Research on Women's Health *Agenda for Research on Women's Health for the 21st Century*, Volumes 1-6.

ORDER FORM

Agenda for Research on Women's Health for the 21st Century is a 6-volume report from four scientific meetings and public hearings to establish an agenda for women's health research for the 21st century. Volume 1 contains the executive summary and volume 2 is a composite report containing recommendations from all four meetings. Volume 3 contains public testimony from the Bethesda, Maryland meeting, and volumes 4, 5, and 6 are reports and public testimony from the three regional meetings and public hearings. To order a single, free copy of each volume, please indicate which publication(s) you would like to receive.

☐ Volume 1 — *Agenda for Research on Women's Health for the 21st Century*, A Report of the Task Force on the NIH Women's Health Research Agenda for the 21st Century, Executive Summary; NIH Publication No. 99-4385.

☐ Volume 2 — *Agenda for Research on Women's Health for the 21st Century*, A Report of the Task Force on the NIH Women's Health Research Agenda for the 21st Century; NIH Publication No. 99-4386.

☐ Volume 3 — *Agenda for Research on Women's Health for the 21st Century*, Public Testimony; Bethesda, Maryland: November 1997; NIH Publication No. 99-4387.

☐ Volume 4 — *Agenda for Research on Women's Health for the 21st Century*, Influences of Sex and Gender on Health; Philadelphia Scientific Meeting and Public Hearing, September 1996; NIH Publication No. 99-4388.

☐ Volume 5 — *Agenda for Research on Women's Health for the 21st Century*, Sex and Gender Perspectives for Women's Health Research; New Orleans Scientific Meeting and Public Hearing, June 1997; NIH Publication No. 99-4389.

☐ Volume 6 — *Agenda for Research on Women's Health for the 21st Century*, Differences Among Populations of Women; Santa Fe, New Mexico, Scientific Meeting and Public Hearing, July 1997; NIH Publication No. 99-4390.

Name _____

Title _____

Affiliation _____

Address _____

_____

Telephone Number _____ Email _____

☐ Please check here if you would like to be added to the Office of Research on Women's Health mailing list.

Please mail or fax this completed form to: Office of Research on Women's Health, Office of the Director, National Institutes of Health, 1 Center Drive, Room 201, MSC 0161, Bethesda, Maryland 20892-0161; fax: 301-402-1798.

Department of Health and Human Services
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